APPENDIX

RULES AND REGULATIONS OF THE STATE BOARD OF WORKERS' COMPENSATION

Rule 2. **Procedure to Elect Coverage, Reject Coverage or Revoke Exemption.**

(a) Corporate officers and limited liability company members electing to be exempt from coverage or electing to revoke exemption and reinstate coverage shall file Form WC-10 with the insurer, if there is an insurer, and, if none, then with the Board.

(b) Farm labor employers electing coverage or electing to revoke previously elected coverage shall file Form WC-10 with the insurer, if there is an insurer, and, if none, then with the Board. If an employer elects to revoke previously elected coverage, the employer must give written notice to each affected employee and must maintain adequate documentation of such notice.

(c) A partner or sole proprietor electing coverage or electing to revoke previously elected coverage shall file Form WC-10 with the insurer, if there is an insurer, and, if none, then with the Board.

Rule 13. **Termination of Dependency.**

(a) The employer/insurer may terminate dependency benefits on the basis of a meretricious relationship only by order of the Board.

(b) In all other cases of termination of dependency, Rule 61(b)(3) shall apply.

Rule 15. **Stipulated Settlements.**

(a) The party submitting the stipulation shall:
- (1) file the original with a copy for each party to the agreement;
- (2) at the top page of each stipulation list the names, addresses, and telephone numbers of all parties to the agreement, the claim number of the employee, the dates of accident covered by the agreement, the names and addresses of all attorneys with a designation of which parties they represent, and the Federal tax identification number of the employee's attorney;
- (3) submit 9 1/2 x 12 ½ envelopes addressed to each party to the agreement;
- (4) attach a copy of the Form WC-1 and WC-4 for each date of accident covered by the settlement;
- (5) attach a copy of the fee contract of counsel for the employee/claimant; and,
- (6) attach the most recent medical report or summary which describes the medical condition of the employee, including a very brief statement of the surgical history, if any, if that history is not already specified within the stipulation. The entire medical record should NOT be attached.

(b) A stipulation which provides for liability of the employer or insurer shall:
- (1) state the legal and/or factual matters about which the parties disagree; and,
- (2) state that all incurred medical expenses which were reasonable and necessary have been or will be paid by the employer/insurer. If the parties have agreed for medical treatment to be provided for a specific period in the future, then the stipulation must so state, and must further specify whether the agreement is limited to certain specific providers, and whether those providers may refer to others if needed. Furthermore, the stipulation shall provide that the parties will petition the Board for a change of physician in the event that a specifically named physician is unable to render services, and the parties cannot agree. If the stipulation does not contain a provision that medical expenses may be incurred for a specific period in the future after the approval of the stipulation,

then the stipulation must contain a statement which explains why that provision is not necessary.

(c) The insurer shall certify that it has complied with O.C.G.A. § 34-9-15 by having sent a copy of the proposed settlement to the employer prior to any party having signed it.

(d) If the agreement provides for a structured settlement to be paid by a party other than the employer or the insurer, then the stipulation must contain a provision that the employer and insurer will be liable for the agreement in the event of the default or failure of that third party to pay.

(e) Unless otherwise specified in the attorney fee contract filed with the Board and in the terms of the stipulation, the proceeds of the approved stipulated settlement agreement shall be sent directly to the employee or claimant. If an attorney is to be paid, the stipulation must state the amount of the fee, and itemize all expenses which should be reimbursed. Expenses and attorney fees shall be paid in a check payable to the attorney only, and proceeds due to the employee shall be paid in a check payable to the employee only.

(f) A final completed Form WC-4 must be filed with every no-liability stipulation for each date of accident covered in that stipulation. In all no liability settlements where the claimant is represented by counsel, the attorney must submit a Form WC-15 certifying that any fee charged is fair and reasonable and does not exceed twenty five percent as allowed under the provisions of O.C.G.A. § 34-9-108 and Board Rule 108.

(g) Stipulations which contain waivers or releases of causes of action over which the Board has no jurisdiction will not be approved by the Board.

(h) The Board may hear evidence or make informal inquiry regarding any settlement.

Rule 24. Procedure for Enforcement Division to Request a Hearing.

(a) The Fraud and Compliance Unit created pursuant to OCGA 34-9-24 shall be known as the Enforcement Division of the State Board of Workers' Compensation.

(b) A request for an action or proceeding may be filed by the State Board of Workers' Compensation Enforcement Division to determine the assessment of civil penalties against any person or entity who has violated the provisions of Chapter 9 of Title 34. The request shall be filed on Form WC-24 and then assigned to an Administrative Law Judge for review. Hearings shall be conducted pursuant to O.C.G.A. § 34-9-102 and Board Rule 102. In addition, venue may be determined as provided by law pertaining to that person or entity.

(c) Any party appealing a decision of the Administrative Law Judge shall do so pursuant to O.C.G.A. §§ 34-9-103 and 34-9-105, and Board Rules 103 and 105.

(d) During an investigation of alleged noncompliance with the provisions of Chapter 9 of Title 34, the Enforcement Division of the State Board of Workers' Compensation may issue a notice for verification of coverage directing the employer, within fifteen days of the date of the notice, to provide either proof of worker's compensation coverage or proof as to why the employer is not subject to the Act. This notice shall be considered a directive of the Board.

Rule 40. Offices and Addresses of the Board; Sessions.

The offices of the State Board of Workers' Compensation are located as follows:

Atlanta:	270 Peachtree Street, N.W. Suite 400 Atlanta, GA 30303-1299 Phone: (404) 656-3875 1-800-533-0682 www.sbwc.georgia.gov	
Albany:	Suite 203, Albany Towers 235 Roosevelt Avenue Albany, GA 31701 Phone: (229) 430-4280	P.O. Box 1649 Albany, GA 31702
Augusta:	1056 Claussen Road Suite 224 Augusta, GA 30907 Phone: (706) 667-4062	
Columbus:	Heritage Tower, Suite 200 18 9th Street Columbus, GA 31902 Phone: (706) 649-1103	P.O. Box 710 Columbus, GA 31902
Covington:	6253 Highway 278, N.E. Price Cutter Plaza Covington, GA 30014 Phone: (770) 784-3133	
Dalton:	Suite 315 415 East Walnut Avenue Dalton, GA 30721-4406 Phone: (706) 272-2284	
Gainesville:	311 Green Street, Suite 402 Gainesville, GA 30501 Phone: (770) 535-5713	
Macon:	110 Holiday Drive, N. Suite A Macon, GA 31210-1802 Phone: (478) 471-2051	
Rome:	104 East 5th Avenue Rome, GA 30161-3128 Phone: (706) 295-6781	
Savannah:	Suite 601 Seven East Congress St. Savannah, GA 31401 Phone: (912) 651-6222	

The Board shall meet in Atlanta, or elsewhere as necessary, at the call of the Board.

Rule 48. **Reserved.**

Rule 60. Adoption and Amendment of Rules of the Board; Assignment of Identification Numbers for Claimants; Form of Documents Submitted to Board; Enforcement Powers.

(a) The rules of the Board are subject to amendment at any time. The Board may adopt additional rules whenever deemed necessary. However, except in extraordinary circumstances, rule changes will only be considered and adopted annually, to be effective on July 1 of each year.

(b) Prior to the adoption, amendment, or repeal of any rule, other than interpretive rules or general statements of policy, the Board shall:

(i) Provide a copy of the proposed rule to the Chairperson of the Board's Advisory Council.

(ii) Provide a copy of the proposed rule to the Chairman of the Senate Industry and Labor Committee and the Chairman of the House Industrial Relations Committee. At the request of the Chairman of the Senate Industry and Labor Committee or the Chairman of the House Industrial Relations Committee, the Board shall hold a hearing on the proposed changes.

(c) Upon receipt of notice of injury, the Board shall assign the employee's social security number or other number to the accident report. All forms, reports, and correspondence concerning any accident that has been reported to the Board must have affixed thereto the employee's assigned number and the date of the accident.

(d) Written instructions on all workers' compensation forms are deemed to be included in these rules.

(e) The Board shall have the power to issue writs of fieri facias in order to collect fines imposed by any member of the Board or any Administrative Law Judge against any person. Such writs may be enforced in the same manner as a similar writ issued by a superior court.

(f) No pleadings, documents or other filings, with the exception of a notice of claim filed on the final day allowed pursuant to statute, will be accepted by facsimile transmission unless specifically requested by the Board. The name of the person requesting the facsimile transmission shall be shown on the cover of the transmission. The certificate of service, showing concurrent service upon the opposing party by facsimile transmission, if available, shall be a part of any facsimile transmission. Failure to include a certificate of service shall invalidate the filing. All facsimiles must be identical to the originals and must be legible. The Board, within its discretion, may transmit documents by facsimile or electronic transmission. Acceptance of electronic mail transmissions requires prior approval from the Board.

Rule 61. Publication of Notice of Operation Under Act; Forms.

(a) All employers operating under the Georgia Workers' Compensation Law shall post notice as hereinafter provided upon durable material publicly and permanently in a conspicuous place in each business location. Upon request, the Board will furnish suitable notices free of charge. The notice shall be in such form that it can be understood by all employees and read as follows:

This business operates under the Georgia Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, OR AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR OR FOREMAN OF THE EMPLOYER.

If the worker is hurt or injured at work, the employer/insurer shall pay medical and rehabilitation expenses within the limits of the law. In some cases, the employer will also be required to pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days.

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of Board forms on file with the employer pertaining to an employee's claim.

The Board may excuse lack of notice of injury if the employer does not follow the foregoing requirements for posting notice. [O.C.G.A. § 34-9-80]

(b) The Board furnishes, upon request, copies of forms required by law. Use originals of the forms or approved copies of the original forms. When a form is filed with the Board, it must be the same color as required, and if printed material appears on the back of the Board form, then all photocopies of the form must consist of both the back and the front. The text and format of a Board form may not be altered, except with the specific written permission of the Executive Director. **ANYONE USING A BOARD FORM MUST USE THE MOST CURRENTLY REVISED VERSION OF THE FORM.**

(1) **Form WC-1 (Color of paper: White). Employer's First Report of Injury.** Employers shall complete Section A immediately upon knowledge of an injury and submit the form to their insurer. Insurers who receive a Form WC-1 from an employer shall clearly stamp the date of receipt on the form. Insurers and self-insured employers shall complete Section B or C and mail the original to the Board and a copy to the employee within 21 days of the employer's knowledge of disability. Use this form to report accidents and injuries for cases involving more than seven days of lost time. Cases with seven or less days of lost time should be reported on Form WC-26. For cases previously reported on Form WC-26, boldly stamp in red “MEDICAL ONLY” on the front of the form (WC-1). In death cases with accident dates before July 1, 1995, a copy of Form WC-1 shall also be filed with the Administrator of the Subsequent Injury Trust Fund at the same time it is mailed to the Board. Further, Form WC-1 shall be filed within 48 hours of the employer's acceptance of a catastrophic injury as compensable. Complete Section B when the employer/insurer commence payment of weekly benefits or when the employer continues to pay salary during compensable disability and when employer/insurer suspend for an actual return to work prior to the filing of Form WC-1. Furnish copy to employee. Complete Section C within 21 days in accordance with subsection (d) of O.C.G.A. § 34-9-221 when employer/insurer controverts payment of compensation. Furnish copies to employee and, upon request, to any other person with a financial interest in the claim. In addition, complete and file a Case Progress Report, Form WC-4, within 90 days of the date of claimed disability.

(2) **Form WC-2 (Color of paper: White). Notice of Payment or Suspension of Benefits.**
File Form WC-2 to commence, suspend, or amend the weekly benefit payment, including payment of salary for compensability, or when a change in disability

status occurs after Form WC-1 has been properly filed with the Board. File when suspending O.C.G.A. § 34-9-261 benefits and commencing O.C.G.A. § 34-9-262 benefits pursuant to § 34-9-104(a)(2). Mail a copy of the Form WC-2 and attachments, if any, to the employee and their attorney, if one has been retained. *See,* Rule 221. If the last payment is intended to close the case, file final Form WC-4 with the Board and mail a copy to the employee.

(3) **Form WC-2A (Color of paper: White). Notice of Payment or Suspension of Death Benefits.**
Use in death case in lieu of Form WC-2. Use when change in dependency occurs.

(4) **Form WC-3 (Color of paper: White). Notice to Controvert.**
Complete Form WC-3 to controvert when a Form WC-1 has previously been filed. Furnish copies to employee and any other person with a financial interest in the claim including, but not limited to, the treating physician(s) and attorney(s) in the claim. *See* subsections (d), (h), and (i) of O.C.G.A. § 34-9-221 and Rule 221. In addition, complete and file a final Form WC-4 within 90 days of the date of the controvert.

(5) **Form WC-4 (Color of paper: White).**
Case Progress Report. File as follows:
(A) Within 180 days of the first date of disability;
(B) Within 30 days from last payment for closure;
(C) Upon request of the Board;
(D) Every 12 months from the date of the last filing of a Form WC-4 on all open cases;
(E) To reopen a case;
(F) With all no- liability settlement documents and within 30 days of final payment made pursuant to an approved liability settlement.
(G) Within 90 days of receipt of an open case by the new third party administrator.

(6) **Form WC-6 (Color of paper: White). Wage Statement.**
File this or the appropriate section of the Form WC-1 when the weekly benefit is less than the maximum under O.C.G.A. § 34-9-261 or § 34-9-262 and furnish a copy to the employee. If a party makes a written request of the employer/insurer, then the employer must send the requesting party a completed Form WC-6 within 30 days, but should not send a copy to the Board.

(7) **Form WC-10 (Color of paper: White). Notice to Elect or Reject Coverage.**
A sole proprietor or partner must file this form to elect coverage under the provisions of O.C.G.A. § 34-9-2.2. The employer/insurer must file this form in order that the corporate officer or limited liability company member be exempt from coverage, or to revoke their previously filed exemption. Rejection becomes effective the date of filing with the insurer, if there is one; and, if none, with the Board. The farm labor employer must file this form in order to request coverage for farm laborers, or to revoke their previously filed request.

(8) **Form WC-11 (Color of paper: White). Standard Coverage Form.**

(9) **Form WC-12 (Color of paper: White). Request for Copy of Board Records.**
Any person requesting a copy of Board records shall file their request on this form. Any person who receives a copy of a Board record pursuant to their request shall pay the charges due within 30 days of receipt of an invoice from the Board.

(10) **Form WC-14 (Color of paper: White). Notice of Claim/Request for Hearing or Mediation.**
File to open a claim, request a hearing, or request a mediation conference. Furnish a copy of Form WC-14 to all other parties. (A request for hearing by an employee will be considered only after the time required of the employer/insurer to make the first payment of income benefits has expired as provided in O.C.G.A. § 34-9-221.)

(11) **Form WC-15 (Color of paper: White). Attorney Certification for No-Liability Stipulated Settlements.**
Must be attached to all no-liability stipulated settlements.

(12) **Form WC-20(a) (Color of paper: White). Medical Report.**
This report and/or the HCFA 1500, HCFA 1450, and/or UB92 shall be completed and filed as follows:

(A) The attending physician or other practitioner makes the report and forwards it along with office notes and other narratives to the employer/insurer as follows:
  (i) Within seven days of initial treatment;
  (ii) Upon the employee's discharge by the attending physician;
  (iii) At least every three months until the employee is discharged;
  (iv) Upon the employee's release to return to work;
  (v) When a permanent partial disability rating is determined.
  (vi) Pursuant to Rule 203(b).

(B) The employer/insurer shall file the report including office notes and narratives with the Board within 10 days after receipt as follows:
  (i) When the report contains a permanent partial disability rating;
  (ii) Upon request of the Board; and,
  (iii) To comply with other rules and regulations of the Board.

(C) The employer/insurer shall maintain copies of all medical reports and attachments in their files and shall not file medical reports except in compliance with this rule and Rule 200(c).

(13) **Form WC-24 (Color of paper: White). Enforcement Division Request for Board Intervention.**
For use by Enforcement Division only.

(14) **Form WC-25 (Color of paper: White). Application for Lump Sum/Advance Payment.**
See Board Rule 222.

(15) **Form WC-26 (Color of paper: White). Yearly Report of Medical Only Cases.**
File on or before January 31 following each calendar year in respect to payments for injuries not reported on Form WC-1. File annually even if no reportable injuries or payment occurred during the reporting year.

(16) **Form WC-R1 (Color of paper: White). Request for Rehabilitation.**
The employer/insurer shall file:

(A) Within 48 hours of the employer's acceptance of a catastrophic injury as compensable, simultaneously with the Form WC-1, naming a catastrophic supplier;

(B) Within 15 days of notification that rehabilitation is required to request a rehabilitation supplier;

(C) When the employer/insurer requests a supplier for cases with dates of injury prior to July 1, 1992;

(D) When the employer/insurer requests a change of supplier;
(E) To request reopening of rehabilitation; or
(F) Upon request of the Board.

The employee or employee's attorney shall file a Form WC-R1 to request appointment of a supplier for cases with dates of injury prior to July 1, 1992, for change of supplier or reopening of rehabilitation.

A case party shall file a Form WC-R1 when a stipulated settlement provides for rehabilitation and rehabilitation is not already on the case. A case party may file a Form WC-R1 to request an extension of vocational rehabilitation services for cases with dates of injury prior to July 1, 1992.

All required information shall be supplied and shall be legible. The certificate of service must be completed and the date mailed must be indicated.

(17) **Form WC-R1CATEE (Color of Paper: White). Employee Request for Catastrophic Designation.**

The employee or employee's attorney shall file:
(A) If the employer/insurer fail to timely designate the claim catastrophic and the employee believes the case to qualify for catastrophic designation;
(B) With supporting documentation;
(C) Presenting a choice for a Board Certified catastrophic rehabilitation supplier.

(18) **Form WC-R2 (Color of paper: White). Rehabilitation Transmittal Report.**

The principal rehabilitation supplier shall file:
(A) To accompany updated narrative progress reports on catastrophic cases every 90 days;
(B) To request a rehabilitation conference or prepare for a rehabilitation conference;
(C) With all progress reports as required by the Board not submitted with a Form WC-R2A and when a stipulation request has been submitted;
(D) Upon request of the Board;
(E) To report medical care coordination services for non-catastrophic cases with dates of injury prior to July 1, 1992.

(19) **Form WC-R2A (Color of paper: White). Individualized Rehabilitation Plan.**

The principal rehabilitation supplier shall file within 60 calendar days from the date of appointment; not later than 30 calendar days prior to the end of the current rehabilitation period to request extension of services, or to amend an approved plan 30 calendar days prior to the date of plan expiration.

(20) **Form WC-R3 (Color of paper: White). Request for Rehabilitation Closure.**

The principal rehabilitation supplier shall file this form:
(A) Following 60 days of return to work status;
(B) When further services are not needed or feasible;
(C) When a stipulated settlement has been approved by the Board that does not include further rehabilitation services; or
(D) When the Board has closed the case.

(21) **Form WC-P1 (Color of paper: Pink). Panel of Physicians.**

(22) **Form WC-P2 (Color of paper: Pink). Conformed Panel of Physicians.**

(23) **Form WC-P3 (Color of paper: Pink). WC CO Panel.**

To be utilized only by employers/insurers contracted with a Board Certified Managed Care Organization.

(24) **Form WC-100 (Color of Paper: White). Request for Settlement Mediation.**
To be used when a party is requesting a settlement mediation.

(25) **Form WC-102 (Color of paper: White). Request for Documents from Parties.**
Prior or subsequent to a hearing being requested in a claim, the parties shall be entitled to request copies of documents listed in this form from the opposing parties, and the named documents shall be provided to the requesting party within 30 days of the date of certificate of service, subject to penalties for failure to comply.

(26) **Form WC-102D (Color of paper: White). Motion/Objection to Motion.**
A party who makes or objects to a motion shall use this form, if no other specific Board form exists for the motion or request, and shall serve a copy on all counsel and unrepresented parties.

(27) **Form WC-102B (Color of paper: White). Notice of Representation of a Party Other Than a Claimant.**

(28) **Form WC-102C (Color of paper: White). Attorney Leave of Absence.**
An attorney who is counsel of record, and wishes to obtain a Leave of Absence, must file this form with the Atlanta office of the Board. If granted, the leave will cover all cases for which the attorney is counsel of record which are not calendared on the date of approval.

(29) **Form WC-104 (Color of paper: White). Notice to Employee of Medical Release to Return to Work with Restrictions or Limitations.**
For non-catastrophic accidents occurring on or after July 1, 1992, the employer/insurer must send this form to the employee no later than 60 days after the medical release of the employee to return to work with restrictions or limitations, and file a copy with the Board.

(30) **Form WC-108a (Color of paper: White). Attorney Fee Approval.**
An attorney shall file this form in order to request approval of a fee contract, an assessed fee by consent, and for resolution of a fee lien dispute by consent, when there is no pending litigation, and shall serve a copy on all counsel and unrepresented parties.

(31) **Form WC-108b (Color of paper: White). Attorney Withdrawal/Attorney Fee Lien.**
An attorney who wishes to withdraw must file this form and follow the procedure set out in Rule 108(b). An attorney of record who chooses to file a lien for services and/or request for reimbursement of expenses after withdrawal from representation or after services are terminated, in writing, by a client, shall file this form with supporting documentation, and serve a copy on all counsel and unrepresented parties.

(32) **Form WC-121 (Color of paper: White). Notice of Use of Servicing Agent.**
An insurer, self-insurer, or self-insurance fund shall file this to give notice of the employment of a servicing agent and of the termination of services of a servicing agent.

(33) **Form WC-200a (Color of paper: White). Change of Physician/Additional Treatment by Consent.**
Parties who agree on a change of physician/additional treatment shall file a properly executed Form WC-200a with the Board, with copies provided to the named medical provider(s) and parties to the claim, which form shall be deemed to be approved and made the order of the Board pursuant to O.C.G.A. § 34-9-200(b) unless otherwise ordered by the Board.

(34) **Form WC-200b (Color of paper: White). Request/Objection for Change of Physician/Additional Treatment.**
A party who requests a change of physician or additional treatment without consent, or who objects to a request which has been made, shall file this form with the Board, and serve a copy on all counsel and unrepresented parties. Objections must be filed within 15 days of the date on the certificate of service on the request.

(35) **Form WC-205 (Color of paper: White). Request for Authorization of Treatment or Testing by Authorized Medical Provider.**
Authorized medical providers seeking approval for treatment or testing shall send this form by facsimile or e-mail directly to the insurer/self-insurer who must fax or e-mail a response within five business days. Neither the request nor response shall be filed with the Board, unless otherwise requested.

(36) **Form WC-206 (Color of paper: White). Reimbursement Request of Group Health Insurance Carrier/Healthcare Provider.**
A group health insurance carrier or health care provider which requests reimbursement of medical expenses shall file this form during the pendency of a claim, and serve a copy on all counsel and unrepresented parties.

(37) **Form WC-207 (Color of paper: White). Authorization and Consent to Release Information.**
Employer/insurers seeking the release of medical information pursuant to O.C.G.A. § 34-9-207 may utilize this form to receive consent from the employee.

(38) **Form WC-208a (Color of paper: White). Application for certification of WC/MCO.**

(39) **Form WC-226(a) (Color of paper: White). Petition for Appointment of Temporary Guardianship of Minor.**
A party petitioning for the Board to appoint a temporary guardian to receive and administer workers' compensation benefits for a minor may file this form with the WC-14 or when submitting a settlement agreement and shall serve a copy on all counsel and unrepresented parties.

(40) **Form WC-226(b) (Color of paper: White). Petition for Appointment of Temporary Guardianship of Legally Incapacitated Adult.**
A party petitioning for the Board to appoint a temporary guardian to receive and administer workers' compensation benefits for a legally incapacitated adult may file this form with the WC-14 or when submitting a settlement agreement and shall serve a copy on all counsel and unrepresented parties.

(41) **Form WC-240 (Color of paper: White). Notice to Employee of Offer of Suitable Employment.**
The employer/insurer shall use this form to notify an employee of an offer of employment which is suitable to his/her impaired condition as required by

O.C.G.A. § 34-9-240, and shall provide it to the employee and his/her attorney at least 10 days prior to the date the employee is scheduled to return to work, filing a copy with the Board.

(42) **Form WC-240A (Color of Paper: White). Job Analysis.**
An employer/insurer may use this form in conjunction with a Form WC-240 to provide a detailed job description when notifying an employee of an offer of employment which is suitable to his/her impaired condition as required by O.C.G.A. {34-9-240, and shall provide it to the employee and his/her attorney at least 10 days prior to the date the employee is scheduled to return to work, filing a copy with the Board.

(43) **Form WC-243 (Color of paper: White). Reduction in Benefits.**
An employer/insurer seeking a credit pursuant to O.C.G.A. § 34-9-243 shall file this with the Board and send a copy to all counsel and unrepresented parties. The employer/insurer must specify the amount of unemployment compensation and/or income payments made to the employee pursuant to a disability plan, a wage continuation plan, or a disability insurance policy, and shall specify the ratio of the employer's contributions to the total contributions of such plan or policy.

(44) **Form WC-244 (Color of paper: White). Reimbursement Request of Group Insurance Carrier/Disability Benefits Provider.**
A group insurance carrier or disability benefits provider which requests reimbursement of disability benefits shall file this form during the pendency of a claim, and serve a copy on all counsel and unrepresented parties.

Rule 63. Proration of Board's Expenses.

The premium to be reported to the Board for the purpose of assessment shall be the “direct net earned premium”. The minimum assessment based upon the administrative cost necessary to provide licensure support and basic computer management reports shall be $100 annually for each insurer and self-insurer.

Rule 81.1. Bill of Rights.

The employer shall post the summary of rights, benefits, and obligations which is required by O.C.G.A. § 34-9-81.1 and is provided by the Board in the same location as the panel of physicians which is required by O.C.G.A. § 34-9-201.

Rule 82. Statute of Limitation and Procedure for Filing Claims.

(a) Any defense as to the time of filing a claim is waived unless it is made no later than the first hearing.

(b) A party filing a claim should file Form WC-14 with the Board, along with five copies when also requesting a hearing, and serve a copy on all other parties.

Rule 100. Alternative Dispute Resolution (ADR) Unit.

(a) An Alternative Dispute Resolution Unit is established to resolve disputes without the necessity of a hearing.

(b) Hearing requests or motions will be screened in order to identify cases likely to be resolved by Board order or the mediation process without a hearing.

(c) In addition, the ADR Unit and each Administrative Law Judge shall have the authority to direct the parties to attend a mediation conference when deemed appropriate by the Board. The Board's authority to direct the parties to attend a mediation conference shall extend to include mediation of disputes which arise in cases designated as “Medical Only.” Participation in a mediation conference shall not abridge the rights of the parties to a subsequent evidentiary hearing or ruling on the contested issues should the issues not be successfully resolved through mediation. An expedited hearing may be scheduled by agreement of the parties subsequent to the conference being held. An agreement reached at mediation will be reduced to writing and shall have the full effect of an award or order issued by the Board. A settlement agreement reached through the mediation process must be submitted and reviewed pursuant to O.C.G.A. § 34-9-15 and Board Rule 15.

(d) Parties requesting a Board mediation for the purpose of an all issues settlement must file a Form WC-100 certifying that all parties are in agreement with the request for a settlement mediation and that the employer/insurer has, or will have by the date of the first scheduled mediation conference, authority to resolve the claim based upon a good faith evaluation. The WC-100 must be served on all parties and parties at interest simultaneous with the board filing.

(e) All communications that take place within the context of a mediation conference are confidential and may not be disclosed at a subsequent hearing nor submitted in support of or in response to any motion. However, when the parties have been ordered to submit the names of physicians in a change of physician dispute and the dispute is not resolved through mediation, each party's list shall be submitted for consideration by the Administrative Law Judge.

(f) Each party to the dispute is required to have in attendance at the mediation conference a person or persons who have adequate authority to resolve all pending issues. The employee shall be in attendance at the mediation conference. The employer shall have in attendance at the mediation conference a representative of the employer/insurer who has authority to resolve all pending issues. The requirement of the presence of the employer/insurer's representative shall not be satisfied by the presence of legal counsel of the employer. In claims where the Subsequent Injury Trust Fund (SITF) is a party-at-interest to the claim, a representative of the SITF must either be in attendance at the mediation conference or have extended settlement authority to the representative of the employer/insurer no later than two business days prior to the date of the conference. Exceptions to the attendance requirement may be granted upon permission of an Administrative Law Judge from the ADR Unit or his/her designee, obtained prior to the conference date.

(g) Any person ordered by the Board to participate in a mediation conference and who fails to attend the scheduled conference without reasonable grounds may be subject to civil penalties, attorney's fees, and/or costs. The postponement and rescheduling of a mediation conference shall be granted by agreement of the parties or at the discretion of an Administrative Law Judge from the ADR Unit or his/her designee upon good cause shown. Any party requesting cancellation or rescheduling of a mediation conference shall provide notice to all parties and shall notify the ADR Unit no later than 4:30 p.m. on the date before the scheduled conference.

Rule 102. Attorneys Entitled to Practice Before the Board; Reporting Requirements; Postponements, Leave of Absence, and Legal Conflicts; Conduct of Hearings; Motions and Interlocutory Orders; Discovery and Submission of Evidence; Written Responses.

(a) Attorneys Entitled to Practice before the Board: Rule 2-101 of the Georgia Rules of Professional Conduct, as now in effect or as hereinafter amended, is controlling as to the practice of law before the Board and its Administrative Law Judges.

(b) Reporting Requirements:

(1) The address of record of an employee shall be that address shown on the most recent document filed with the Board.

(2) A party shall provide notice to the Board of the intent to obtain legal representation and the name of its legal representative, if any, within 21 days from the date of the hearing notice, subject to an assessment of penalties for failure to comply.

(3) The address of record of an employer shall be the address shown on the Form WC-1, the address on file with a Licensed Rating Organization filed by the insurer on behalf of the employer, or the principal office of the employer within the State of Georgia.

(4) Any party requesting a hearing shall furnish the correct name and current address of the employee, the employer, and the insurer/self insurer and third party administrator at the time the hearing is requested.

(5) An attorney who represents a party other than an employee or a claimant in a contested matter must file a notice of representation on a Form WC-102B with the Board, and must serve a copy on all counsel and unrepresented parties.

(6) An attorney who represents an employee or claimant in a contested matter shall file a fee contract as notice of representation and must serve a copy on all counsel and unrepresented parties. The contract must be dated, conform to Rule 108, and both the attorney and the client must sign the contract.

(c) Postponements, Leaves of Absence, and Legal Conflicts:

(1) Postponement: If a hearing is on a calendar for the first time, and if all parties agree to postpone it to be rescheduled, they may obtain the postponement without consulting the Administrative Law Judge before whom it is scheduled, absent prior specific instructions from the judge to the contrary. This agreement must be communicated to the judge no later than 4:30 p.m. of the business day immediately preceding the hearing by the party who requested the hearing, or by any other party by agreement. Otherwise, a hearing shall be postponed only upon strict legal grounds, or at the discretion of the Board or an Administrative Law Judge. For a case that has already been postponed, a second or subsequent request to postpone the case from a calendar must be approved by the Administrative Law Judge. If the judge determines that the case is not ready for trial at this time, the claim may be removed from the calendar, not to be reset until the parties certify that discovery is complete and the case is ready to be tried.

(2) Leave of absence. In the event that an attorney wishes to obtain a leave of absence from the Board, the request should be submitted on a Form WC-102C and mailed to the Atlanta office of the State Board of Workers' Compensation. The granting of a leave of absence will not apply to cases already calendared on the date the leave is signed, and will apply only to court appearances and mediations. In the event that leave is requested for a date already calendared, the attorney must request a postponement from the Administrative Law Judge, with permission of opposing counsel or by conference call, prior to the hearing or mediation.

(3) For the purpose of resolving requests for continuance based upon legal conflict, Rule 17.1(B)(4) of the Uniform Rules of the Superior Courts shall apply. The action which was first filed shall take precedence, subject to judicial discretion.

(d) Motions and Interlocutory Orders Pending a Hearing:

(1) All motions for which a specific Board form does not exist shall be made on Form WC-102D. Any party filing a motion shall also serve a copy, along with supporting documents, on all counsel and unrepresented parties.

(2) Prior to filing a motion, including requests for documents made pursuant to Rule 102(F)(1), the moving party shall confer with the opposing party, or counsel if the party is represented, in a good-faith effort to resolve the matters involved.

(3) A party objecting to a motion shall respond on a Form WC-102D, which must be filed with the Board within 15 days of the date of the certificate of service on the request, and shall serve a copy on all counsel and unrepresented parties.

(4) An Administrative Law Judge may issue an interlocutory order suspending or reinstating payment of weekly benefits to an employee pending an evidentiary hearing.

(5) Where the issue is which of two or more employer/insurers is liable, the Administrative Law Judge or the Board may issue an interlocutory order directing the employer or one of the insurers to pay weekly benefits and medical expenses until the determination of liability of an insurer has been made. Reimbursement may thereafter be ordered where appropriate.

(e) Conduct of Hearings:

(1) No person shall, during the course of a proceeding before an Administrative Law Judge or Director, engage in any discourteous or disruptive conduct.

(2) Any violation of the Georgia Rules of Professional Conduct of the State Bar of Georgia may subject an attorney to the assessment of a civil penalty pursuant to OCGA {34-9-18 and referral to the State Bar of Georgia for disciplinary action.

(3) (A) All medical evidence regarding the treatment, testing or evaluation of the claimant for the accident which is the subject of the hearing should be exchanged between the parties as soon as practicable, but no later than ten days prior to the hearing, and all depositions should be completed prior to the hearing.

(B) If the amount of the average weekly wage is in dispute, counsel shall exchange written contentions with respect to their methods of calculation at least ten days prior to the hearing, and shall present the written contentions to the Administrative Law Judge at the commencement of the hearing.

(C) If accompanied by an affidavit, a written laboratory test result report is admissible into evidence for purposes of authenticity only. Any other evidentiary objections can be raised by the parties in motions or at evidentiary hearings.

(4) Parties may be allowed to make arguments either by the filing of briefs within the time set by the Administrative Law Judge at the hearing, by oral argument at the conclusion of the presentation of evidence at the hearing, or both. Oral argument shall be limited to five minutes for each party.

(5) It is the policy of the Board to encourage the parties to close the record at the conclusion of the hearing. The parties are expected to make diligent efforts to present all the evidence at the hearing, without the need for the record to remain open.

(6) Hearing Transcript: Any Administrative Law Judge is authorized to relieve the court reporter of the duty of transcribing the record of proceedings. The record shall be transcribed and submitted to the Board or the superior court if there is an application for review of an appeal. The appellant shall serve a copy of the

application for review or appeal on the court reporter at the same time it is served on all other persons.

(f) Discovery and Submission of Evidence:

(1) Prior or subsequent to a request for hearing being filed in a claim, the parties shall be entitled to receive from each other without cost the documents specified in Form WC-102. These documents shall be provided within 30 days of the date of the certificate of service, subject to an assessment of penalties for failure to comply. Neither the request nor response shall be filed with the Board.

(2) Discovery filed pursuant to the Civil Practice Act shall only be permitted after a hearing has been requested in the claim, or as otherwise specified in these rules.

(3) Discovery documents, including but not limited to depositions, interrogatories, and notices to produce, shall not be filed with the Board until such time as they are tendered in evidence in a proceeding before the Board. Correspondence between the parties shall not be filed with the Board.

(4) All documents, transcripts, exhibits, and other papers filed with the State Board of Workers' Compensation shall be submitted on 8-1/2 by 11 inch paper only. Sufficient space shall be left at the top of all documents (at least one and one-half inches) so that all information will remain readable after the documents have been filed. Copies of items offered in evidence at a hearing must be properly identified and tendered to opposing parties at the hearing.

(g) Written Responses: The filing of all written responses will be governed in accordance with O.C.G.A. {9-11-6(e).

Rule 103. Appeals to the Appellate Division.

(a) The time for application for review commences on the date shown on the notice of award and is computed as in paragraph (3) of subsection (d) of O.C.G.A. § 1-3-1.

(b) Appearance before the Appellate Division shall be by brief only unless a request for oral argument is made at the time the application for review is filed by appeal or cross appeal. Within 10 days from the date of the certificate of service on the application for review, the appellee or cross appellee may request oral argument. Oral argument shall be limited to five minutes for each party.

(1) Any party applying for review shall serve a copy of the application for review and enumerations of errors allegedly made by the Administrative Law Judge upon all opposing parties. Failure to file enumerations of error with the Board may result in the dismissal of the appeal or cross appeal.

(2) The party requesting review shall have 20 days from the date shown on the certificate of service of the application for review in which to file a brief. The party requesting the review shall certify that a copy of the brief was served in person or by mail to all opposing parties on the date the brief is submitted to the Board. Opposing parties shall then have 20 days from the date of appellant's or cross appellant's certificate of service to file reply briefs with the Board. Briefs not filed in conformity with this rule will not be accepted except by permission of the Board.

(3) Upon application for oral argument, the party making the application shall file with the Board seven copies of the enumerations of error and of the award of the Administrative Law Judge, including all amendments, for which the review is requested.

(4) Briefs shall generally follow the format required by the appellate courts. Only the original of the brief is required to be filed with the Board.

(5) Where a case has been scheduled on a calendar for oral argument, no more than one postponement will be granted to reschedule the argument. If the argument cannot be made within that time, the claim may be reviewed on briefs only.
(6) Any party scheduled for oral argument shall notify the Appellate Division no later than 4:30 the day before the scheduled appearance if they do not intend to appear.
(7) Amicus curiae briefs may be filed without permission any time before a decision is issued. The amicus brief shall disclose the identity and interest of the person or group on whose behalf the brief is filed.

(c) The Board will apply the law of Georgia regarding the tenure and character of newly discovered evidence required for the granting of a new trial.

(d) The Board will not accept an application for review of an interlocutory order unless the Administrative Law Judge, in the exercise of his or her discretion, certifies that the order or decision is of such importance to the case that immediate review should be had. In the event the Administrative Law Judge certifies his or her interlocutory order for immediate review, in order for the Appellate Division to have jurisdiction under O.C.G.A. 34-9-103(a), a party must file an application for review with the Appellate Division within twenty days of the date of the original interlocutory order.

(e) No person appearing before the Appellate Division shall engage in any undignified or discourteous conduct.

(f) Upon determining that an appeal has been prosecuted without reasonable grounds, the Appellate Division shall have the authority to assess penalties and attorneys' fees against the offending party.

Rule 104. Suspension/Reinstatement of Benefits.

When converting from temporary total disability benefits to temporary partial disability benefits, under the authority of O.C.G.A. § 34-9-104(a)(2), the employer/insurer shall file a Form WC-2 specifying: (1) that the injury has not been designated catastrophic under O.C.G.A. 34-9-200.1(g);(2) that the employee has been released to return to work with restrictions for at least 52 consecutive weeks, or 78 aggregate weeks; and (3) that the Form WC-104 with all required attachments was sent to the employee no later than 60 days after the date that the employee was determined able to return to work. A copy of the medical report demonstrating that the employee has been found medically capable of performing work with limitations shall be attached to the form WC-2 documenting the statutory change in condition. The Form WC-2 and Form WC-104 with attachments shall be sent to the employee and to the employee's attorney at the same time these forms are filed with the Board.

Rule 105. Appeals to the Courts.

(a) The prevailing party shall supply the Board with copies of the following documents:
(1) Order of Superior Court disposing of an appeal;
(2) Denial by the Court of Appeals or Supreme Court of an application for discretionary review;
(3) Notice of appeal from Superior Court to Court of Appeals or Supreme Court where discretionary appeal is granted;
(4) Denial of certiorari by the Supreme Court from a decision of the Court of Appeals;

(5) Court of Appeals remittitur to Superior Court;
(6) Judgment on remittitur from Superior Court when the Court of Appeals does anything other than affirm the judgment of the Superior Court.

(b) The non-prevailing party shall supply the Board with the following documents:
(1) Application to the Court of Appeals or Supreme Court for discretionary review of a judgment of the Superior Court;
(2) Application to the Supreme Court for certiorari to review a decision of the Court of Appeals;
(3) Notice from the Supreme Court of granting of certiorari from a decision of the Court of Appeals.

(c) The party dismissing an appeal shall file a copy of the dismissal with the Board.

(d) In the event of a settlement during the pendency of an appeal, it shall be the joint obligation of the parties to supply the Board with copies of all documents necessary to restore jurisdiction to the Board to consider the settlement.

(e) Copies of the documents listed above shall be submitted to the Board by regular mail within five days of filing in the appropriate court.

Rule 108. Attorney's Fees.

The attorney's fee shall not exceed 400 weeks of income benefits unless sooner terminated or suspended as provided by law or at the Board's discretion. An extension may be granted by order of the Board based upon an application filed prior to the expiration of 400 weeks of income benefits and demonstrating good cause for the granting of an extension.

(a) Attorney fee contracts. Immediately upon being employed by an employee or claimant in a matter which is before the Board, the attorney shall file a contract of employment and fees with the Board. This contract shall be dated, and shall be signed by both the attorney and the client, and shall include the following statement with respect to an accident occurring on or after July 1, 1992: This contract is subject to the approval of the State Board of Workers' Compensation, and no fee of more than $100.00 shall be paid under the contract unless approved by the Board. No contract shall be filed with the Board which provides for a fee greater than 25 percent of the recovery of weekly benefits. Any contract with these terms, absent compelling evidence to the contrary, shall be deemed to represent the reasonable fee of the attorney. With respect to an accident occurring before July 1, 1992, the contract shall include the following statement: This contract is subject to the approval of the State Board of Workers' Compensation, and no fee of more than $100.00 shall be paid under the contract unless approved by the Board. No contract concerning an accident occurring before July 1, 1992, shall be filed with the Board which provides for a fee greater than 25 percent of the recovery of weekly benefits without a hearing, 30 percent of the recovery of weekly benefits with extensive discovery preparatory for a hearing, and 33-1/3 percent of the recovery of weekly benefits after a hearing. Any contract with these terms, absent compelling evidence to the contrary, shall be deemed to represent the reasonable fee of the attorney. An attorney who requests approval of his or her fee contract when there is no pending litigation shall file with the Board Form WC-108a. When an attorney requests approval of his or her fee contract after a hearing notice has been issued and after the dispute has been resolved, that attorney shall file Form WC-108a with the Administrative Law Judge who issued the hearing notice.

(b) (1) The value of the services of the attorney may be agreed upon by the parties subject to approval of the Board.

(2) Any offer to make payment if the party waives a claim for attorney's fees under paragraph (2) or (3) of subsection (b) of O.C.G.A. § 34-9-108, or any agreement to waive a claim for attorney's fees as a condition to payment of income or medical benefits, where the only consideration for such waiver is the commencement of income or medical benefits, shall be void *ab initio.*

(3) No party shall be required to pay an attorney for services for which the fee was assessed against the opposing party.

(4) An attorney advertising to render services to a potential workers' compensation claimant must intend to render said services and shall not divide a fee with another attorney who is not a partner in or associate of his or her law firm unless:

1. The client consents to associating the other attorney after full disclosure that the fee will be divided; and,
2. The fee division is made in direct proportion to the services and responsibility performed and assumed by each attorney; and,
3. The total fee of the attorneys shall not exceed a reasonable fee for the claim. **No party shall be required to pay for the services of an attorney who violates the provisions of O.C.G.A. § 34-9-108(c).**

(5) Upon assessing attorney's fees, costs may be assessed against the offending party which are payable to the Board in an amount not less than $250.00. The Administrative Law Judge may assess higher costs based on the length of the hearing, time traveled, and time lost from other duties. In any case where a determination is made that proceedings have been brought, prosecuted, or defended in whole or in part without reasonable grounds, the Administrative Law Judge or the Board may, in addition to assessed attorney's fees, award to the adverse party reasonable litigation expenses, in whole or in part, against the offending party. Reasonable litigation expenses under this subsection are limited to witness fees and mileage pursuant to O.C.G.A. § 24-10-24; reasonable expert witness fees (subject to the Fee Schedule, where applicable); reasonable deposition costs; and the cost of the hearing transcript.

(6) When requesting payment of attorney's fees at a hearing pursuant to O.C.G.A. § 34-9-108, the party making the request shall be required to demonstrate the reasonableness of the attorney's fees requested by placing into the record expert testimony as to the value of services rendered. Counsel may testify personally or in affidavit form at the hearing, subject to cross-examination, as to expert status and the reasonable value of the services rendered in order to meet this requirement. No attorney's fees will be awarded pursuant to O.C.G.A. § 34-9-108 absent this evidence being placed in the record.

(7) When the parties agree to an assessment of attorney's fees the attorney who is to receive the assessed fee shall file with the Board Form WC-108a, serve a copy on all parties or their counsel, and sign the certificate of service on the form.

(c) Solicitation of Services. See O.C.G.A. §§ 34-9-22, 34-9-30, 34-9-31 and 34-9-32.

(d) An attorney who has made an appearance by filing Form WC-14 or by filing a fee contract and who wishes to withdraw as counsel for any party therein, shall file a Form WC-108b with the Board. The form shall be sent in an envelope addressed specifically to the Administrative Law Judge if a hearing notice has been sent by that judge and the case is still in litigation, or, if not, the form shall be sent to the Atlanta office of the Board.

(e) An attorney of record who chooses to file a lien for services must do so by filing written notice of the contended value of such services with the Board on Form WC-108b within 20 days after (i) withdrawal from the case, or (ii) notice of termination of the contract in

writing by the client. The attorney of record filing a lien shall serve a copy of Form WC-108b on all unrepresented parties and counsel. Failure to attach supporting documentation will result in the lien being denied. If the Board includes the issue of approval of the fee lien for determination at a hearing or mediation, and the attorney who filed the lien fails to appear and present evidence in support of the lien, then it shall be void. If all parties agree to resolution of a fee lien request prior to the initiation of litigation, then one of them must file with the Board Form WC-108b. Failure to perfect a lien in this manner will be considered a waiver of further attorneys' fees.

(f) No attorney shall charge to any client as an expense of litigation any portion of any referral fee or membership charged by any lawyer referral service, or nonspecific office costs.

Rule 121. Insurance in More Than One Company; Self-Insurance; Insurance by Counties and Municipalities.

(a) A compensation policy must cover all of the operations of an employer, except as hereinafter provided. An employer has the right to place insurance with more than one insurer; but if this is done with respect to distinct operations, the policies must be concurrent and the written portions must read alike. If there is any difference in coverage, it can be expressed as applying to a fractional part thereof. If an employer has more than one place of business, each operation can be covered separately unless the business is interchangeable. Each insurer on the risk must cover alike all the employees coming under the law.

(b) Any employer desiring to become a self-insurer shall apply on the form prescribed by the Self-Insurers Guaranty Trust Fund Board of Trustees and approved by the Board. All inquiries must be answered fully and will be treated as strictly confidential. The Self-Insurers Board of Trustees, with the approval of the Board, shall set the amount of security in the form of a surety bond or letter of credit to be required, but in no event shall the amount be less than $100,000.00. It shall be at the discretion of the Self-Insurers Guaranty Trust Fund Board of Trustees if other forms of security are acceptable. Each case will be considered on its own merits with strict regard to the hazards of the business involved. So long as an employer shall continue solvent and promptly pay any and all compensation legally due in accordance with the provision of the law there shall be no effort to collect under the securities.

(c) Counties, municipalities, and other political subdivisions must qualify as self-insurers or obtain insurance coverage. Permission for self-insurance by municipalities and political subdivisions may be granted by application therefore and without deposit of surety bonds security. Assurance must be given the Board, however, that provision will be made for the payment of all awards.

(d) When an insurer, self-insurer, or group self-insurance fund obtains the services of a servicing agent or third party administrator for the purpose of administering workers' compensation matters, the insurer, self-insurer, or group self-insurance fund shall give notice to the Board on Form WC-121 of the name and address of the servicing agent or third party administrator, the name, address and telephone number of a contact person with that third party administrator or servicing agent, the effective date of the servicing agent's or third party administrator's commencement of services, and if applicable, the ending date of those services, and shall file Form WC-121 with the Board no later than the agreed commencement date of those services. The insurer, self-insurer, or group self-insurance fund shall also give notice by regular mail of the servicing agent's or third party administrator's name, address and telephone number to the claimants in all existing claims for which it is commencing administration within 14 days of commencing

services. When the relationship between the insurer, self-insurer or group self-insurance fund and the servicing agent or third party administrator is terminated, the insurer, self-insurer, or group self-insurance fund shall file Form WC-121 with the State Board of Workers' Compensation no later than 30 days prior to the date of cessation of services, and shall give notice, by regular mail to all claimants in existing claims which it has been administering.

(e) Within 10 days from the date an employer determines its inability to make payment for workers' compensation benefits, the employer shall notify its surety and the Board in writing of its inability to fulfill its obligations under the Act. Upon receipt of information establishing an employer's inability to meet its obligations under the Act, or upon notice from an employer that it is unable to meet its obligations under the Act, the Board shall make demand of the surety for payment of the bond or other security held. The Board shall give written notice of the demand for payment to the employer, and all claimants affected by this proceeding. After the Board receives the proceeds of the bond or other security, then the Board shall determine whether the amount of the security is sufficient to pay all of the employer's obligations arising under this Chapter. If it is not sufficient, the Board shall apportion the proceeds of the bond, or other security held for distribution. The Board may enter into an agreement with a servicing agent or the Georgia Self-Insurers Guaranty Trust Fund to administer the settlement of claims pursuant to this section.

(f) Rules for third party administrators/servicing agents.

(1) A third party administrator/servicing agent must be licensed by the Office of Commissioner of Insurance pursuant to O.C.G.A. § 33-23-100 and follow the Rules and Regulations of the Insurance Commissioner's Office Chapter 120-2-49 entitled Administrator Regulations.

(2) The third party administrator/servicing agent must comply with all sections of O.C.G.A. § 34-9 and all rules and regulations of the Board.

(3) Workers' Compensation claim files of third party administrators/servicing agents are subject to audit by the Board at any time.

(4) The transfer of files from one third party administrator/servicing agent to another must be handled in a professional and timely manner.

(i) Open indemnity files must be current as of the date of transfer and the transferring (former) third party administrator/servicing agent must include in the file a complete current Form WC-4 (completed within the last 30 days) reflecting all payments made as of the date of transfer. The transferring third party administrator/servicing agent must at the date of transfer provide the receiving third party administrator with a payment history on all Medical Only claims with an occurrence date of 90 days or less as of the date of transfer. Penalties for noncompliance by the transferring third party administrator/servicing agent would be in accordance with O.C.G.A. § 34-9-18(a).

(ii) The receiving (new) third party administrator/servicing agent must notify all active (open) claimants of the change in administration within 14 days of receiving the files. Vendors must be notified within 60 days of receipt of medical bills or service invoices.

Rule 126. Proof of Compliance with Insurance Provisions.

(a) Every employer insured by a licensed insurer shall have proof of coverage documented by its insurer directly with a Licensed Rating Organization through their policy information system. Every employee leasing company shall have proof of coverage documented with a Licensed Rating Organization of the initiation or termination of any contractual relationship with a client company; for the purposes of this Rule, the term

employee leasing company shall refer to both; (1) any employee leasing company defined in O.C.G.A. § 34-8-32, and (2) any professional employer organization as defined in O.C.G.A. § 34-7-6. Reports will be made to the Licensed Rating Organization pursuant to procedures outlined by the Licensed Rating Organization and approved by the Georgia State Board of Workers' Compensation.

(1) The proof of coverage documented with a Licensed Rating Organization is evidence that coverage is in effect until superseded or terminated.

(2) Termination

(i) Non-renewals
The expiration date documented by a Licensed Rating Organization shall be considered the date of termination on all non-renewals.

(ii) Mid-term cancellation
A mid-term cancellation documented with a Licensed Rating Organization is evidence that coverage is terminated, effective not less than 15 days after filing except where the provisions of Title 33 provide for an earlier effective date.

(b) Group self-insurance funds operating pursuant to the Georgia Workers' Compensation Act shall file with the Board a separate report for each insured member employer on Standard Coverage Form WC-11 on or before the effective date of coverage.

(1) The filing of Form WC-11 is evidence that coverage is in effect until superseded or terminated.

(2) The filing of a cancellation on Form WC-11 is evidence that coverage is terminated, effective not less than 15 days after filing.

(3) If the insured member employer operates under different trade names, a separate Form WC-11 must be filed for each trade name, properly cross-referenced.

(4) Group self-insurance funds shall file a separate Form WC-11 for each insured member of the fund by July 1, 1987.

(c) Self-insurers must give written notice to the Board addressed to the Director of Licensure and Quality Assurance when they add or delete subsidiaries, affiliates, divisions or locations to their self-insurance certificate, or make any changes in their excess insurance policies. (See Rule 382(d).)

Rule 127. Permits for Self-Insurance; Establishment of Offices.

In order for a certificate to be granted by the Board under O.C.G.A. § 34-9-127, the employer desiring to become a self-insurer must designate an office in the State of Georgia for the handling of claims or, if claims are handled out of state, shall designate an agent located in the State of Georgia who shall be authorized to execute instruments for the payment of compensation in an emergency (or, if necessary). Every service organization or office handling claims for self-insurance under the law shall be staffed during normal working hours and be available for immediate telephone contact with the Board and the public through a toll free telephone number. During normal working hours at this office, at least one staff member shall be authorized to execute (negotiable instruments) checks for the payment of compensation. Certificates to self-insure shall be continuous unless the self-insurer fails to meet the requirements of the Board.

Rule 131. Designation by Insurer of Office for Service of Notices.

The most recent address of record filed with the Board shall be used by the Board for service of all notice and orders.

Rule 200. Compensation for Medical Care; Changes in Treatment; Filing of Medical Reports; Requests for Medical Information.

(a) (1) The employer/insurer have a duty to provide all reasonable and necessary medical treatment in a timely manner and to give appropriate assistance in contacting medical providers when necessary. The employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries.

(2) Payment of compensation for costs by the employer or its insurer directly to the providers of medical, surgical and hospital care and other treatment, items, or services on behalf of the employee or directly to the employee shall satisfy employer's obligation to furnish the employee compensation for costs of such medical, surgical, hospital care and other treatment, items and services provided for by O.C.G.A. § 34-9-200(a).

(b) (1) Changes in treatment. Except as provided in subsection (b) of O.C.G.A. § 34-9-201, changes of physician or treatment are made only by agreement of the parties or by order of the Board. If there has been no hearing requested, a party requesting a change shall make a good faith effort to reach agreement on the change before requesting an order from the Board. If an agreement cannot be reached, the party requesting the change shall make the request on Form WC-200b, file it with the Board, serve a copy on all parties or their counsel, and sign the certificate of service on the form. In cases that have been designated as "Medical Only", the requesting party shall file a Form WC-14 Notice of Claim or a Form WC-1 along with the Form WC-200b in order for the Board to process the request. The party making the request must specify the reason for the requested change, as well as the date that the change shall be effective. If the argument in support of the request is based on testimony, then an affidavit must be attached to the form, and if the argument refers to documents, then a copy of the documents must be attached. If the Board grants a change, the effective date will be the date that the Form WC-200b was filed, unless otherwise specified. Any party who objects to the request for a change in physician or treatment shall also file their objections on a Form WC-200b with the Board within 15 days of the date of the certificate of service on the request, serving a copy on all unrepresented parties and counsel. Affidavits and documents must be attached as specified above. If a hearing has been requested, the party requesting a change of physician or treatment may include the request in the original request for hearing, or amend the hearing request within 15 days prior to the date of the hearing to include the issue of change of physician or treatment. Upon consideration of the evidence, the Administrative Law Judge will render a decision on all the issues presented. If the parties agree on a change of physician or treatment, a properly executed Form WC-200a may be filed with the Board, with copies provided to the named medical provider(s) and parties to the claim, which form shall be deemed approved and made the order of the Board pursuant to O.C.G.A. § 34-9-200(b), unless otherwise ordered by the Board.

(2) The party requesting/objecting to a change in physician shall set forth reasons why the change will/will not benefit the employee, or provide the employee with medical care reasonably required to effect a cure, give relief, or restore the employee to suitable employment. Factors which may be considered in support of the request/objection may include, but are not limited to, the following:

(i) Proximity of physician's office to employee's residence;
(ii) Accessibility of physician to employee;
(iii) Excessive/redundant performance of medical procedures;
(iv) Necessity for specialized medical care;

(v) Language barrier;
(vi) Referral by authorized physician;
(vii) Noncompliance of physician with Board Rules and procedures;
(viii) Panel of physicians;
(ix) Duration of treatment without appreciable improvement;
(x) Number of prior treating physicians;
(xi) Prior requests for change of physician/treatment;
(xii) Employee released to normal duty work by current authorized treating physician;
(xiii) Current physician indicates nothing more to offer.

(c) (1) As long as an employee is receiving compensation, he or she shall submit himself or herself to examination by the authorized treating physician scheduled by the employer/insurer at reasonable times and with reasonable notice. If the employee refuses to submit himself or herself to or in any way obstructs such an examination requested by and provided for by the employer, upon order of the board his or her right to compensation shall be suspended until such refusal or objection ceases and no compensation shall at any time be payable for the period of suspension unless in the opinion of the board the circumstances justify the refusal or obstruction.

(2) Nothing contained herein shall be construed to abridge the employee's continued right to schedule his/her appointments for authorized medical treatment.

(d) The employer/insurer may suspend weekly benefits for refusal of the employee to submit to treatment only by order of the Board.

(e) Medical Reports.
The employer/insurer shall not file with the Board a medical report for any injury which occurred after January 1, 1989, except as follows:

(1) The report or its attachments contains a permanent partial disability rating (file within 10 days of employer/insurer's receipt);

(2) A rehabilitation plan is filed with the Board. In such instance the medical reports shall be filed with the rehabilitation plan;

(3) Medical reports are requested by the Board (file within 10 days of request.) Any additional medical reports required shall be filed within 10 days of the employer/insurer's receipt of same. The employer/insurer shall maintain copies of all medical reports in their files and shall not file medical reports except in compliance with this Rule.

(f) (1) Requests for Medical Information. The employee shall, upon the request of the employer/insurer, furnish copies of all medical records and reports which are in his/her possession concerning the treatment for the accident which is the subject of the claim. The employee shall furnish the copies within 30 days of the date of the request. The employer/insurer shall pay the reasonable cost of the copies as provided by the Board-approved fee schedule.

(2) The employer/insurer shall, upon the request of the employee, furnish a copy of the posted panel of physicians, and copies of all medical records and reports in their possession, concerning the treatment for the accident which is the subject of the claim, and shall, upon request of the employee, furnish copies of all medical records and reports which were obtained with a release of the employee provided pursuant to O.C.G.A. § 34-9-207(b), within 30 days of the date of the request at no expense to the employee.

(3) Upon failure of either party to furnish information as provided above, the physician or other medical providers shall, upon request, furnish copies of all medical reports and bills in their possession concerning the treatment for the

accident which is the subject of the claim, at no expense to the employee or his/her attorney. A reasonable cost for copies pursuant to the fee schedule may be charged against the party determined to be responsible for payment of medical expenses. Nothing in this Rule shall limit an employee's right to obtain a complete copy of his/her medical records from any health care provider.

Rule 200.1. Provision of Rehabilitation Services.

(a) REHABILITATION SERVICES

(1) Definitions:

(i) Rehabilitation services by a Board registered rehabilitation supplier are required in claims where the injury is catastrophic and for non-catastrophic claims with dates of injury prior to July 1, 1992. Services of a Board registered rehabilitation supplier may be utilized in all other non-catastrophic claims only upon written agreement of all parties. Consistent with O.C.G.A. {34-9 and Board Rules, a rehabilitation supplier delivers and coordinates services under an individualized Rehabilitation Plan; facilitates coordination of medical care; provides vocational counseling, exploration, and assessment; performs job analysis, job development, modification, and placement, evaluates social, medical, vocational, psychological, and psychiatric information; and may provide additional services upon agreement of the parties or Board order. The rehabilitation supplier shall comply with the professional standards and code of ethics as set forth by his or her certification or licensure board. Neither rehabilitation suppliers nor case managers operating under O.C.G.A. { 34-9-208 shall provide services in a workers' compensation claim until and unless registered with, or certified by, the Board.

(ii) Case managers may be involved in cases where the employer/insurer has contracted with a certified workers' compensation managed care organization (WC-MCO). These case managers shall operate pursuant to the provisions of O.C.G.A. { 34-9-208 and Board Ru1e 208.

(iii) Other than the appointed rehabilitation supplier as defined by O.C.G.A. {34-9-200.1 and Board Rule 200.1, or a case manager as defined by O.C.G.A. {34-9-2O8 and Board Rule 208, only a direct employee of the insurer, third party administrator, or employer may communicate with an injured employee and/or the authorized treating physicians to assess, plan, implement, coordinate, monitor, and evaluate options and services relative to an injured employee's condition and/or vocational needs. The individual shall identify himself to others as an employee of the insurer, third party administrator, or employer and shall not identify himself as a case manager, rehabilitation supplier, or with any other term suggesting a fiduciary relationship with the injured employee. Nothing contained in this portion of the Board Rule shall apply to an attorney representing a party.

(2) Unauthorized Activities:

Rehabilitation suppliers and case managers not registered with the Board or any person performing any of the activities described in subsections (a)(1) of this Board Rule who is not a direct employee of the insurer, third party administrator or employer, shall be subject to civil penalties in accordance with O.C.G.A. {34-9-18. Complaints pertaining to unregistered or unauthorized rehabilitation suppliers and case managers should be directed in writing to the Director of the Managed Care & Rehabilitation Division of the Board, with copies to all case parties and the rehabilitation supplier. Upon receipt of a complaint, the Director shall investigate the alleged violation and may refer the

issue to the Enforcement Division and/or the Legal Division of the Board for further investigation or for the scheduling of an evidentiary hearing for a determination of whether or not penalties are warranted.

(3) Appointment of Board Registered Rehabilitation Supplier:

(i) In all catastrophic injury claims, within forty-eight hours of accepting the injury as compensable, or notification of a final determination of compensability, the employer/insurer shall appoint a Board registered catastrophic rehabilitation supplier. The employer/insurer shall file a Form WC-R1 with the Board simultaneously with the Employer's First Report of Injury (WC-1), or by filing a WC-R1 within twenty days of notification of an administrative decision that rehabilitation services are required.

(ii) If the employer/insurer does not timely appoint a registered catastrophic rehabilitation supplier as required pursuant to subsection (a)(3)(i), the employee shall file a WC-R1CATEE to request appointment of a registered catastrophic supplier with service to all parties and the requested supplier.

(iii) For non-catastrophic claims with date of injury prior to July 1, 1992, unless excused by the Board, any party may file a WC-R1 at any time requesting the appointment of a registered rehabilitation supplier subject to the opposing party's right to file an objection within twenty days. If the Board deems rehabilitation is appropriate, the Board may appoint a rehabilitation supplier.

(iv) Absent written objections filed with the Board within fifteen days of the date of the certificate of service on the WC-R1 or WC-R1CATEE, the request for rehabilitation services will be approved if, in the judgment of the Board, the appointment is appropriate. In the event written objection has been timely filed, the Board shall make a determination regarding appointment of a supplier and notify all parties.

(4) Rehabilitation Supplier Duties:

(i) A rehabilitation supplier is not a party to the case. The registered rehabilitation supplier shall have sole responsibility for the rehabilitation aspects of each individual case. The registered rehabilitation supplier shall communicate with the injured employee and others to assess, plan, implement and coordinate, monitor and evaluate options and services to meet an injured employee's health care needs through communication and available resources to promote cost effective outcomes with a goal of return to work.

(ii) The registered rehabilitation supplier shall meet with the injured employee within thirty days of appointment and complete an initial rehabilitation evaluation and an appropriate plan for medical and vocational services. The initial rehabilitation plan must be filed with the Board on Form WC-R2A within sixty days of the supplier's appointment to the claim, unless excused by the Board. A current Rehabilitation Plan must be filed with the Board during all phases of service delivery.

(iii) In the event that a Board approved Rehabilitation Plan proposes that services be provided to the employee that are outside the scope of the qualifications or expertise of the appointed registered supplier, the registered rehabilitation supplier may obtain those specific services from another qualified individual, facility, or agency.

(iv) For catastrophic claims, the registered catastrophic rehabilitation supplier shall file a WC-R2 and all accompanying rehabilitation reports every ninety days.

(v) For non-catastrophic claims with dates of injury prior to July 1, 1992, the registered rehabilitation supplier shall file a WC-R2 with all

rehabilitation reports and available medical information not previously submitted, every twenty-six weeks.

(vi) All rehabilitation plans shall be submitted with a current narrative report justifying the proposed action, which may include all pertinent medical documentation, evaluation reports, progress reports made since the last rehabilitation plan, labor market surveys, and other documentation. If the Board rejects the proposed rehabilitation plan, the registered rehabilitation supplier shall have 30 days to submit a revised plan. The registered rehabilitation supplier shall develop and submit an amended rehabilitation plan on a WC-R2A at any time that the circumstances change significantly such that the goals, activities, and timeliness of the current approved rehabilitation plan are no longer applicable or realistic. Amended or extended rehabilitation plans shall be submitted thirty days prior to the expiration of the current approved plan.

(5) Rehabilitation Plans:

(i) A Medical Care Coordination Plan assists catastrophically injured employees in attaining maximum medical improvement and independence in activities of daily living. Each individual medical care coordination plan shall be in place for no longer than one year.

(ii) An Independent Living Plan encompasses those items and services, including housing and transportation, which are reasonable and necessary for a catastrophically injured employee to return to the least restrictive lifestyle possible. Each individual independent living plan shall be in place no longer than one year.

(iii) An Extended Evaluation Plan provides evaluation to establish vocational feasibility and appropriate vocational goals. The extended evaluation plan may include medical care coordination services to meet medical care goals. The extended evaluation plan shall be in place for no longer than one year.

(iv) A Return-to-Work Plan assists with job placement in order to return an employee to suitable employment. Return-to work plans, in order of preference, are: 1) return to same job with the same employer; 2) return to different job with same employer; 3) return to work with new employer; 4) short-term training; 5) long-term training; or 6) self-employment. The return-to-work plan shall be in place for no longer than a one-year period. Following an actual return to work, the plan may be extended for no longer than sixty days for the purpose of monitoring the return to work.

(v) A Training Plan documents the feasibility and necessity of vocational training. Each individual training plan shall be in place for no longer than one year.

(vi) A Self-Employment Plan is considered only when return-to-work plans or training plans are not feasible and when a reasonable probability of success in self-employment can be documented.

(vii) Any party objecting to a proposed rehabilitation plan shall file a written objection with the Board within fifteen days of the date of the certificate of service. The Rehabilitation Division may hold a rehabilitation conference and/or issue an administrative decision.

(6) Communication in Rehabilitation Services:

(i) A rehabilitation supplier shall recognize the employee's attorney as the employee's representative and shall encourage communication among all parties and their attorneys.

(ii) A rehabilitation supplier shall simultaneously provide copies of all correspondence to all parties and their attorneys.

(iii) The rehabilitation supplier shall provide professional identification and shall explain his or her role to any physician at the initial contact with the physician.

(iv) The employee has the right to a private physical examination and/or consultations with the medical provider. The rehabilitation supplier shall not attend such examination, except by the revocable written consent of the employee, or his or her attorney, if represented by counsel, after the employee has been advised of the right to a private examination and/or consultation.

(v) The rehabilitation supplier shall not obtain medical information regarding an injured employee in a private meeting with any treating physician unless the rehabilitation supplier has reserved with the physician sufficient appointment time for the conference and the injured employee and his or her attorney were given ten days advance notice of their option to attend the conference. If the employee is represented by counsel, all efforts shall be made to coordinate the meeting with the employee's attorney. All legal excuses for the injured employee's attorney's inability to attend the conference will be recognized. If the injured employee or the physician does not consent to a joint conference, or if, in the physician's opinion, it is medically contraindicated for the injured employee to participate in the conference, the rehabilitation supplier shall note this in his or her report and may in those specific instances communicate directly with the physician. The rehabilitation supplier shall report to all parties and the employee's attorney the substance of the communication between him or her and the physician. Exceptions to the above notice requirements may be made in cases of medical necessity or with the consent of the injured employee or his or her attorney.

(vi) The rehabilitation supplier shall simultaneously provide copies of all written communications and shall report the substance of all oral communications between him or her and the treating physicians to all parties and their attorneys.

(vii) The rehabilitation supplier may assist the physician in scheduling second opinions and specialized treatment and shall give the injured employee and his or her attorney at least ten days notice of the time and place of any requested examination, unless waived by the Board or by agreement of the parties.

(viii) The rehabilitation supplier may assist in obtaining a permanent partial disability rating from the authorized treating physician.

(7) Rehabilitation Closure:

(i) The registered rehabilitation supplier shall submit a WC-R3, Request for Closure, for all catastrophic and pre-July 1, 1992 claims as follows:

(1) sixty days after the employee's return to work;

(2) at any time it is determined that further services are not needed or feasible;

(3) when a stipulated settlement that does not include rehabilitation services has been approved by the Board; or

(4) when the Board directs rehabilitation closure.

(ii) At any time, upon review of the file, the Board may determine that rehabilitation closure is appropriate and may issue an order or an administrative decision to close rehabilitation.

(iii) A party may request that the Board close rehabilitation services by filing a written request setting forth the specific reasons in support of their request for closure with copies to all parties and the supplier.

(b) CHANGE IN REGISTERED REHABILITATION SUPPLIER

(1) A change in registered rehabilitation supplier shall be requested only by parties to the claim and must be approved by the Board. The WC-R1 requesting a change in supplier shall include the names and addresses of the involved suppliers and the specific reasons the change is requested. The requesting party shall send copies of the WC-R1 to all parties and their attorneys and to involved rehabilitation suppliers and complete the certificate of service on the WC-R1.

(2) When a WC-R1 is filed to request a change of registered rehabilitation supplier, the current Board appointed rehabilitation supplier shall maintain responsibility for providing necessary rehabilitation services until all appeals have been exhausted, unless excused by the Board.

(3) Any party objecting to a change of rehabilitation supplier shall file a written objection with the Board within twenty days of the date of the certificate of service. The Rehabilitation Division may hold a rehabilitation conference and/or issue an administrative decision.

(c) CHALLENGES TO ADMINISTRATIVE DECISIONS

Any party to the claim dissatisfied with an administrative decision must file a WC-14, Request for Hearing, served on all parties and their attorneys and involved rehabilitation supplier within twenty days of the date of the administrative decision. The Board, in its discretion, may order the parties to participate in a mediation conference before the scheduling of the de novo hearing. The administrative decision shall be admissible in evidence.

(d) PEER REVIEW

Peer review shall be the procedure by which disputes concerning the necessity of services and the reasonableness of fees are resolved.

(e) FAILURE OF A PARTY OR COUNSEL TO COOPERATE

(1) Benefits may be suspended for failure or refusal to accept or cooperate with authorized rehabilitation services only by order of the Board.

(2) A party or attorney may be subject to civil penalty or to fee suspension or reduction for failure to cooperate with rehabilitation services. Failure to cooperate may include, but is not limited to, the following:

(i) Interference with the services outlined in a Board approved rehabilitation plan;

(ii) Failure to permit an interview between the employee and supplier within ten days of a request by the supplier or other obstruction of the interview process without reasonable grounds;

(iii) Interference with any party's attempts to obtain updated medical information for purposes of rehabilitation planning;

(iv) Failure to sign and return or object to the proposed rehabilitation plan within fifteen days of receipt; or

(v) Failure to attend a rehabilitation conference without good cause.

(3) At the request of a party, a rehabilitation supplier, an Administrative Law Judge, or the Board's rehabilitation coordinator, the Board may schedule a mediation or an administrative rehabilitation conference to resolve problems relating to the rehabilitation process. The parties should make all efforts to resolve the problems before requesting a mediation or conference. At Board scheduled rehabilitation conferences or mediations, all parties and the rehabilitation supplier may be required to attend or to be represented by a person with full authority to resolve the pending disputes. Agreements reached at mediations or rehabilitation conferences will be reduced to writing. Agreements reached at mediation shall be governed by Rule 100.

(i) Any person notified by the Board who fails to attend a Board scheduled mediation or rehabilitation conference without reasonable grounds may

be subject to sanction pursuant to O.C.G.A. {34-9-18. Any party requesting cancellation or rescheduling of a rehabilitation conference or mediation shall notify the Board and other parties with adequate notice to all parties.

(ii) Following the rehabilitation conference, the Board may issue an administrative decision.

(f) REHABILITATION SUPPLIERS SHALL BE CERTIFIED OR LICENSED AND REGISTERED WITH THE BOARD

(1) Qualified Certifications or Licenses

Any rehabilitation supplier who wishes to supply services in a Workers' Compensation claim shall hold one of the following certifications or licenses:

(i) Certified Rehabilitation Counselor (CRC);
(ii) Certified Disability Management Specialist (CDMS);
(iii) Certified Rehabilitation Registered Nurse (CRRN);
(iv) Work Adjustment and Vocational Evaluation Specialist (WAVES);
(v) Licensed Professional Counselor (LPC);
(vi) Certified Case Manager (CCM);
(vii) Certified Occupational Health Nurse (COHN); or
(viii) Certified Occupational Health Nurse Specialist (COHN-S).

(2) Registration with the Board

(i) To register as a rehabilitation supplier or rehabilitation resident, an applicant shall submit a completed, notarized application and a registration fee of one hundred dollars ($100.00), and shall have official certified post secondary academic transcripts or evidence of professional licensure by the State of Georgia sent directly to the Board. The registration shall be renewed annually. Not later than November 30th each year, an applicant shall submit a completed, notarized renewal application, a renewal fee of fifty dollars ($50.00), and documentation of current certification. Rehabilitation suppliers registered prior to July 1, 1985, who are not certified by CRC, CDMS, WAVES, LPC, CCM, CRRN, COHN, or COHN-S shall continue to renew registration annually. The renewal application for uncertified rehabilitation suppliers shall be accompanied by proof of completion of at least thirty contact hours of approved continuing education units. Any person who fails to renew on or before November 30th, shall be penalized an additional twenty-five dollars ($25.00). Any person who is delinquent on or after January 1st of each year shall be penalized an additional amount up to one hundred dollars ($100.00). A rehabilitation supplier who has not renewed his or her rehabilitation supplier registration by November 30th of the year following his or her supplier registration expiration date, shall not be eligible for renewal. If that individual wishes to provide rehabilitation services to injured employees, he or she will be required to submit a new application to become a rehabilitation supplier in accordance with the first paragraph of this section. In addition, if that supplier was registered as a catastrophic rehabilitation supplier, and wishes to provide catastrophic rehabilitation services, he or she will also be required to re-apply for catastrophic registration pursuant to (4) of this section.

(ii) Notice of a rehabilitation supplier's registration approval will contain a supplier registration number with the November 30th expiration date, which shall be included on all reports submitted to the Board by the rehabilitation supplier.

(iii) An appeal of a denial of an application for registration, renewal, or reinstatement may be made within fifteen days of notification of the denial by letter to the Director of Licensure & Quality Assurance

requesting a hearing. The applicant will be advised by the Board of the date, time, and place of the appeal hearing.

(iv) The Director of Managed Care and Rehabilitation may require a rehabilitation supplier to submit corrective action plans and/or may recommend the assessment of penalties for the violation of Board Rules, consistent submission of inappropriate rehabilitation or medical care plans, consistent failure to timely revise denied rehabilitation plans, and/or unethical behavior during rehabilitation services.

(v) Rehabilitation supplier registration may be revoked or suspended for violation of Board Rules. A complaint against a registered rehabilitation supplier shall be filed in writing, with copies to all case parties and the supplier, with the Director of the Managed Care and Rehabilitation Division of the Board. Upon receipt of a complaint, or upon the Board's knowledge of a violation, the Director of Managed Care and Rehabilitation shall notify the rehabilitation supplier in writing of the nature of the complaint. Within fifteen days of the date of the notice, the rehabilitation supplier shall file with the Director of Managed Care and Rehabilitation a written response to the complaint. If the Director of Managed Care and Rehabilitation determines that justification exists for penalties and/or revocation or suspension of the rehabilitation supplier's registration, the issue will be referred to the Enforcement Division and the Legal Division for a hearing to be held before an Administrative Law Judge. The Administrative Law Judge shall issue an order either dismissing the complaint, assessing penalties and/or revoking or suspending the rehabilitation supplier's registration, or placing the rehabilitation supplier on probation. The rehabilitation supplier may appeal the order of the Administrative Law Judge in accordance with O.C.G.A. {34-9-103 and {34-9-105.

(3) Rehabilitation Resident

(i) An individual who meets the academic and experience criteria and who has applied for and been registered to sit for the examination to be certified or licensed as CRC, CDMS, WAVES, CRRN, LPC, CCM, COHN, or COHN-S may register to be a rehabilitation resident. A resident may provide rehabilitation services under the direct supervision of a registered rehabilitation supplier. However it is the registered rehabilitation supplier who shall perform the initial evaluation and prepare any rehabilitation plans, job analyses, progress reports, or closure report and who has any personal contact with the injured employee.

(ii) In the event a rehabilitation resident does not become certified or licensed by the appropriate licensing board within a two-year period from the date of initial application, the rehabilitation resident shall be disqualified from providing services to injured employees. A rehabilitation resident shall register with the Board on forms supplied by the Board.

(iii) Nothing contained in this subsection shall be construed to permit a rehabilitation resident to act independently as a registered rehabilitation supplier or to relieve the registered rehabilitation supplier from his or her responsibilities in any claim where a rehabilitation resident is utilized.

(iv) Any individual participating in a Council on Rehabilitation Education (CORE) approved master's level program of study practicum/internship shall not be required to register with the Board while completing that short term internship. The registered rehabilitation supplier supervising an educational intern shall be responsible for all activities on the claims.

(4) Registered Catastrophic Rehabilitation Supplier

In order to provide services to catastrophically injured employees, the rehabilitation supplier must be registered with the Board as a catastrophic supplier.

(i) A catastrophic applicant shall have been registered as a rehabilitation supplier for a minimum of two years immediately prior to beginning the catastrophic application process. The applicant for catastrophic supplier registration shall document experience and/or training in at least three of the types of catastrophic injury listed in O.C.G.A. {34-9-200.1(g) 1 through 5. Other detailed requirements for becoming a catastrophic supplier, including education, experience and renewal are set forth in the current edition of the Board's Procedure Manual.

(ii) Within thirty days of the date of a denial of an application for registration as a catastrophic supplier, an appeal may be initiated by filing a written request with the Director of the Board's Licensure and Quality Assurance Division for a conference with the Catastrophic Certification Committee. The applicant will be notified in writing of the date, time, and place of the conference within thirty days of the appeal.

(g) CATASTROPHIC DESIGNATION

(1) When there is no dispute, the employer/insurer shall file a Form WC-R1 requesting a catastrophic designation and an appointment of a registered catastrophic rehabilitation supplier. The claim is automatically accepted as a catastrophic claim.

(2) When a catastrophic designation is disputed, an employee or employee's attorney shall file a WC-R1CATEE, with certificate of service with the Managed Care and Rehabilitation Division to request a catastrophic designation and an appointment of a registered catastrophic rehabilitation supplier. The WC-R1CATEE must be accompanied by documentation as specified in the current edition of the Board's Procedure Manual, or as requested by the Board.

(3) Any objections must be filed with the Board in writing within twenty days of the certificate of service on the WC-R1CATEE. In the alternative, either party may file a Form WC-14 requesting an evidentiary hearing within 20 days of the certificate of service on the WC-R1CATEE. In the event a Form WC-14 is filed, the file shall be transferred to an administrative law judge for an evidentiary hearing without an administrative decision being rendered by the Rehabilitation Coordinator. The timeliness of the objection or hearing request will be processed in accordance with provisions of O.C.G.A. {9-ll-6(e).

(4) The Board's Rehabilitation Coordinator will review the file and render an administrative decision, in writing as soon as possible. Prior to issuing a decision, the Rehabilitation Coordinator may schedule a rehabilitation conference. The administrative decision will be issued, in writing promptly following the conference.

(5) Any party to the claim dissatisfied with the administrative decision must, within twenty days of the date of the administrative decision, file a WC-14, Request for Hearing. The WC-14 must be served on all parties, their attorneys and involved rehabilitation suppliers. The Board, in its discretion, may order the parties to participate in a mediation conference before the scheduling of the de novo hearing.

(6) When no hearing is requested following an administrative decision by a Board Rehabilitation Coordinator or when an administrative law judge determines that an injury is catastrophic, the employer/insurer have 20 days from the date of such administrative decision or administrative law judge’s award to select a Board-registered rehabilitation supplier. If the employer/insurer fails to select a supplier, or requests a hearing without reasonable grounds following an administrative decision, or files an appeal of the administrative law judge’s decision granting catastrophic designation and the catastrophic designation is

upheld on appeal, the Board will select the supplier, and may, in the exercise of its discretion, appoint the supplier requested by the employee.

(h) VOLUNTARY REHABILITATION

Any party may request the appointment of a registered rehabilitation supplier on a voluntary basis upon agreement of the parties. The registered rehabilitation supplier shall be responsible for obtaining the written agreement from the employee. If one party does not consent to voluntary rehabilitation services or subsequently withdraws consent for rehabilitation services, the rehabilitation supplier shall have no further contact, written, oral or otherwise, with the employee, the employee's attorney, or the employee's authorized treating physicians.

(i) PROFESSIONAL RESPONSIBILITIES OF A REHABILITATION SUPPLIER

(1) A rehabilitation supplier may contract as a consultant with an employer/insurer or attorney, to review files, give recommendations regarding case management, safety and rehabilitation issues, and to perform job analyses of employment positions. All recommendations and reviews must be submitted directly to the employer/insurer or its agent requesting rehabilitation services.

(2) The rehabilitation supplier utilized by the parties must hold one of the certifications, or licenses specified in subsection (f) of this Rule and the supplier must be registered with the Board.

(3) A rehabilitation supplier will inform all parties of the legal limitations of their services or the benefits offered to the injured employee. The rehabilitation supplier shall function within the limitations of his or her role, training, and technical competency and will accept only those positions for which he or she is professionally qualified. A rehabilitation supplier will not misrepresent his or her role or competence to an injured employee and will refer the injured employee to a specialist as the needs of the injured employee dictate.

(4) The rehabilitation supplier shall disclose at the outset of a case to health care providers, the parties, and their attorneys any possible conflicts of interest. The rehabilitation supplier shall inform any health care providers, the parties, and their attorneys of his or her assignment and proposed role in the case.

(5) The rehabilitation supplier shall exercise independent professional judgment in making and documenting recommendations for medical and vocational services, including any alternatives for medical treatment and cost-effective return-to-work options including retraining or retirement. The rehabilitation supplier shall acknowledge that the authorized treating physician directs the medical care of an injured employee.

(6) Subject to the qualifications of the rehabilitation supplier, he or she may explain medical information to the injured employee, and shall discuss with the injured employee all treatment options appropriate to the injured employee's conditions.

(7) The rehabilitation supplier shall insure the confidentiality of the injured employee's medical records and shall not disclose the medical records to non-parties without the written consent of the injured employee or unless otherwise legally required to do so.

(8) As an expert witness or consultant, the rehabilitation supplier shall provide unbiased, objective opinions. The limits of his or her relationship shall be clearly defined in writing to all parties.

(9) A rehabilitation supplier shall not conduct or assist any party in claims negotiation, investigative activities, or perform any other non-rehabilitation.

(10) A rehabilitation supplier shall not advise the injured employee as to any legal matter, including but not limited to claims settlement options or procedures, monetary evaluation of claims, or the applicability of benefits of any kind under the Workers' Compensation Act. Rehabilitation suppliers shall advise a non-represented injured employee to direct such questions to the State Board of

Workers' Compensation and a represented injured employee to direct such questions to his or her counsel.

(11) A rehabilitation supplier shall not accept any additional compensation or reward from any source as a result of settlement of a case.

(12) The assigned rehabilitation supplier shall not perform any additional services for either party for compensation not contemplated by the approved plan, unless all parties agree.

(13) A rehabilitation supplier who possesses information concerning an alleged violation of this rule shall reveal such information to the Licensure & Quality Assurance Division of the State Board of Workers' Compensation, unless the information is protected by law.

Rule 201. Panel of Physicians.

(a) The employer may satisfy the requirements for furnishing medical care under O.C.G.A. § 34-9-200 in one of the following manners:

(1) (i) The employer may maintain a traditional posted panel of physicians that shall consist of at least six non-associated physicians, but is not limited to a minimum of six. However, the Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians or groups of physicians are not reasonably accessible. The physicians selected under this subsection from the panel may arrange for any consultation, referral, and extraordinary or other specialized medical services as the nature of the injury shall require without prior authorization from the Board; provided, however, that any medical practitioner providing services as arranged by a primary authorized treating physician under O.C.G.A. § 34-9-201(b)(1) shall not be permitted to arrange for any additional referrals. The physicians and groups listed on the panel shall be counted as a separate choice from the others listed only if they are not associated with the other physicians and groups listed on the panel. The minimum panel shall include an orthopedic physician, and no more than two physicians shall be from industrial clinics. Further, this panel shall include one minority physician. The minority physician so selected must practice within the State of Georgia or be reasonably accessible to the employee's residence. “Minority” shall be defined as a group which has been subjected to prejudice based on race, color, sex, handicap or national origin, including, but not limited to Black Americans, Hispanic Americans, Native Americans or Asian Americans. Failure to include one minority physician on the panel does not necessarily render the panel invalid. The Board reserves the right to allow exceptions when warranted. The employee may make one change from one physician to another on the same panel without prior authorization of the Board. The party which challenges the validity of a panel shall have the burden of proving that the panel violates the provisions of O.C.G.A. § 34-9-201 and Board Rule 201.

(ii) In the event that the Board has granted any exceptions to the panel requirements, all exceptions must be posted at the same location as the panel.

(2) Conformed Panel of Physicians. The employer may maintain a list of physicians that shall be known as the “conformed panel of physicians,” which shall include a minimum of ten physicians, or professional associations, reasonably accessible to employees and providing the same types of healthcare services specified in Board Rule 201(a)(1) and the following additional healthcare services: general surgeons and chiropractors. The physicians and groups listed

on the panel shall be counted as a separate choice from the others listed only if they are not associated with other physicians and groups listed on the panel. Further, this panel shall include one minority physician as specified in Board Rule 201(a)(1). An employee may obtain the services of any physician from the conformed panel and may thereafter also elect to change to another physician on the panel without prior authorization of the Board. The physician so selected will then become the authorized treating physician in control of the employee's medical care and may arrange for any consultation, referral, and extraordinary or other specialized medical services as the nature of the injury shall require without prior authorization of the Board; provided, however, that any of the physicians to whom the employee is referred by the primary authorized treating physician shall not be permitted to arrange for any additional referrals. The party which challenges the validity of the conformed panel shall have the burden of proving that the panel violates the provisions herein.

(3) An employer or the workers' compensation insurer of an employer may contract with a workers' compensation managed care organization certified pursuant to O.C.G.A. § 34-9-208 and Board Rule 208. A “workers' compensation managed care organization” (hereinafter “WC/MCO”) means a plan certified by the Board that provides for the delivery and management of treatment to injured employees under the Georgia Workers' Compensation Act. The party which challenges the validity of the WC/MCO panel shall have the burden of proving that the panel violates the provisions herein. An employer utilizing a WC/MCO may satisfy the notice requirements of O.C.G.A. § 34-9-201(c) by posting a notice in prominent places upon the business premises which includes the following information:

(A) The employer has enrolled with the specified WC/MCO to provide all necessary medical treatment for workers' compensation injuries. An employee with an injury prior to enrollment may continue to receive treatment from the non-participating authorized treating physician until the employee elects to utilize the WC/MCO;

(B) The effective date of the WC/MCO;

(C) The geographical service area (by counties);

(D) The telephone number and address of the administrator for the employer and/or WC/MCO who can answer questions about the managed care plan;

(E) How the employee can access care with the WC/MCO and the toll-free 24-hour telephone number of the managed care plan that informs employees of available services.

(b) The employer/insurer cannot restrict treatment of the employee to the panel of physicians, conformed panel of physicians, or WC/MCO when the claim has been controverted. However, if the controverted claim is subsequently found to be or is accepted as compensable, the employee is authorized to select one of the physicians who has provided treatment for the work-related injury prior to the finding or acceptance of compensability, and after notice has been given to the employer, that physician so selected becomes the authorized treating physician. The employee may thereafter make one change from that physician to another physician without approval of the employer and without an order of the Board. However, any further change of physician or treatment must be in accordance with O.C.G.A. § 34-9-200 and Board Rule 200.

(c) When a case has not been controverted but the employer fails to provide any of the procedures for selection of physicians as set forth in O.C.G.A. § 34-9-201(c), the employee is authorized to select a physician who is not listed on the employer's posted panel of physicians, conformed panel of physicians or WC/MCO. After notice has been given to the employer, that physician so selected becomes the authorized treating physician, and the employee may make one change from that physician to another

physician without approval of the employer and without an order of the Board. However, any further change of physician or treatment must be in accordance with O.C.G.A. § 34-9-200 and Board Rule 200.

(d) A party requesting a change of physician must do so in the manner prescribed by Board Rule 200.

Rule 202. Examinations.

(a) Examinations contemplated by O.C.G.A. § 34-9-202 shall include physical, psychiatric and psychological examinations. An examination shall also include reasonable and necessary testing, including functional capacity evaluations, as ordered by the examining physician.

(b) The examining physician may require prepayment pursuant to the Fee Schedule base amount for the first hour ($500.00). Payment for any additional charges pursuant to the Fee Schedule shall be due within 30 days of receipt of the report and charges by the employer/insurer.

(c) The employer shall give ten days written notice of the time and place of any requested examination. Advance payment of travel expenses required by Rule 203(e) shall accompany such notice.

(d) The employer/insurer shall not suspend weekly benefits for refusal of the employee to submit to examination except by order of the Board.

Rule 203. Payment of Medical Expenses; Procedure When Amount of Expenses are Disputed.

(a) Medical expenses shall be limited to the usual, customary and reasonable charges as found by the Board pursuant to O.C.G.A. § 34-9-205. Employer/insurers may automatically conform charges according to the fee schedule adopted by the Board and the charges listed in the fee schedule shall be presumed usual, customary, and reasonable and shall be paid within 30 days from the date of receipt of charges. Employer/insurers shall not unilaterally change any CPT-4 code of the provider. All automatically conformed charges according to the fee schedule adopted by the Board shall be for the CPT-4 code listed by the provider. In situations where charges have been reduced or payment of a bill denied, the carrier, self-insured employer, or third party administrator shall provide an Explanation of Benefits with payment information explaining why the charge has been reduced or disallowed, along with a narrative explanation of each Explanation of Benefits code used. In all claims, any health service provider whose fee is reduced to conform to the fee schedule and who disputes that fee, or employer/insurers who dispute the CPT-4 code used by the provider for services rendered shall, in the first instance, request peer review of the charges, and may thereafter request a mediation conference or an evidentiary hearing by filing Form WC-14 with the Board. For charges not contained in the fee schedule and which are disputed within 30 days as not being reasonable, usual and customary, the aggrieved party shall follow the procedures provided in subsection (b).

(b) A medical provider or an employee who has incurred expenses for healthcare goods and services or other medical expenses shall submit the charges to the employer or its workers' compensation carrier for payment within one year of the date of service. In the event that the claim or the expense is controverted, the medical expenses or request for reimbursement must be submitted for payment within one year of the date of service or

within one year of the date that the claim is accepted or established as compensable, whichever is later.

(c) Disputes

(1) An employer or insurer shall pay when due all charges deemed reasonable, and follow the procedures set forth in subsection (2) for review of only those specified charges which are disputed.

(2) For charges not contained in the fee schedule and which are disputed as not being the usual, customary and reasonable charges prevailing in the State of Georgia, the employer, insurer, or physician shall file a request for peer review with a peer review organization authorized by the Board within 30 days of the receipt of charges by the employer/insurer, and shall serve a copy of the request and supporting documentation upon all parties and counsel. A request for peer review of chiropractic charges or treatment shall attach to the application 10 copies of the charges and all of the reports dealing with the treatment of the injured employee. A request for peer review of any other treatment or charges shall attach to the application two copies of the charges and all of the reports dealing with the treatment of the injured employee. The peer review committees approved by the Board are as follows: Medical Directors Solutions, LLC; Georgia Psychological Association; Georgia Chiropractic Association, Inc.; Appropriate Utilization Group, LLC; and such other committees as the Board has posted as so designated at its Atlanta office.

(3) Unless peer review is requested as set forth in Rule 203 (b)(2), all reasonable charges for medical, surgical, hospital and pharmacy goods and services shall be payable by the employer or its worker's compensation insurer within 30 days from the date that the employer or the insurer receives the charges and the medical reports required by the Board. Failure of the health care provider to include with its submission of charges the reports or other documents required by the Board, constitutes a defense for the employer or insurer's failure to pay the submitted charges within 30 days of receipt; however, the employer or insurer must submit to the health care provider written notice indicating the need for further documentation within 30 days of receipt of the charges and failure to do so will be deemed a waiver of the right to defend a claim for failure to pay such charges in a timely fashion on the ground that the charges were not properly accompanied by required documentation. Such waiver shall not extend to any other defense the employer and insurer may have with respect to a claim of untimely payment. If any charges for health care goods or services are not paid when due, penalties shall be added to such charges and paid at the same time as, and in addition to, the charges claimed for the health care goods and services. For any payment of charges made more than 30 days after their due date, but paid within 60 days of such date, there shall be added to such charges an amount equal to 10% of the amount due. For any payment of charges made more than 60 days after the due date, but paid within 90 days of such date, there shall be added to such charges an amount equal to 20% of the amount due. For any charges not paid within 90 days of the due date, in addition to the 20% add-on penalty, the employer or insurer shall pay interest on the combined total in an amount equal to 12% per annum from the 91st day after the date the charges were due until full payment is made. All such penalties and interest shall be paid to the provider of the health care goods or services.

(4) The employer, insurer, or physician requesting review must comply with the requirements of the statute, Board Rules, and rules of the appropriate peer review committee before the Board will rule on any disputed charges.

(5) If there is no appropriate peer review committee, the party requesting review may request a mediation conference by filing Form WC-14 with the Board. The charges submitted which conform to the list as published by the Board shall be

prima facie proof of the usual, customary, and reasonable charges for the medical services provided.

(6) The employer/insurer shall, within 30 days from the date that a decision regarding the peer review of charges or treatment is issued by a peer review organization, make payment of disputed charges based upon the recommendations, or request a mediation conference or an evidentiary hearing. The peer review committee shall serve a copy of its decision upon the employee if unrepresented, or the employee's attorney. A physician whose fee has been reduced by the peer review committee shall have 30 days from the date that the recommendation is mailed to request a mediation or hearing. In the event of a hearing or mediation conference, the recommendations of the peer review committee shall be evidence of the usual, customary, and reasonable charges.

(7) In cases where the peer review committee recommends that the fee be reduced, the employer/insurer shall pay the physician the fee amount recommended by the peer review committee less the filing costs initially paid by the employer/insurer. In the event the peer review committee recommends the entire fee be disallowed, the employer/insurer may automatically deduct the filing costs for the peer review from future allowable expenses submitted by the physician for treatment or services rendered to the employee arising out of the same injury.

(d) Medical expenses shall include the reasonable cost of attendant care that is directed by the treating physician, during travel or convalescence.

(e) Medical expenses shall include but are not limited to the reasonable cost of travel between the employee's home and the place of examination or treatment or physical therapy, or the pharmacy. When travel is by private vehicle the rate of mileage shall be 28 cents per mile. Travel expenses beyond the employee's home city shall include the actual cost of meals and lodging. Travel expenses shall further include the actual cost of meals when total elapsed time of the trip to obtain outpatient treatment exceeds four hours. Cost of meals shall not exceed $30 per day.

Rule 204. Subsequent Non-Work Related Injury; Chain of Causation; Burden of Proof.

The employer/insurer shall not suspend weekly benefits on the ground that a subsequent nonwork related injury has broken the chain of causation between the compensable injury and the employee's disability except by the order of the Board. The burden of proving that the chain of causation has been broken shall be upon the employer/insurer.

Rule 205. Necessity of Treatment; Disputes Regarding Authorized Treatment.

(a) Reports required by the Board include State Board of Workers' Compensation Form WC-20(a), or HCFA 1500, HCFC 1450, or UB92 and supporting narrative, if any, properly filled out and with supporting itemized hospital charges, discharge summary, and billings from other authorized providers of service and shall be furnished at no charge to the party responsible for payment. Medical services provided pursuant to the Workers' Compensation Act are not confidential to the employer/insurer who by law are responsible for the payment of services. Hospitals and other medical providers who by their own rules require medical releases shall be responsible for obtaining same at the time of treatment.

(b) (1) Medical treatment/tests prescribed by an authorized treating physician shall be paid, in accordance with the Act, where the treatment/tests are:
(a) Related to the on the job injury;
(b) Reasonably required and appear likely to accomplish any of the following:
(1) Effect a cure;
(2) Give relief;
(3) Restore the employee to suitable employment;
(4) Establish whether or not the medical condition of the employee is casually related to the compensable accident.

(2) Advance authorization for the medical treatment or testing of an injured employee is not required by this Chapter as a condition for payment of services rendered. A Board certified WC/MCO may provide for pre-certification by contract with network providers pursuant to O.C.G.A. § 34-9-201(b)(3).

(3) (a) An authorized medical provider may request advance authorization for treatment or testing by completing Sections 1 and 2 of Board Form WC-205 and faxing or emailing same to the insurer/self-insurer. The insurer/self-insurer shall respond by completing Section 3 of the WC-205 within five (5) business days of receipt of this form. The insurer/self-insurer's response shall be by facsimile transmission or email to the requesting authorized medical provider. If the insurer/self-insurer fail to respond to the WC-205 request within the five business day period, the treatment or testing stands pre-approved.

(b) In the event the insurer/self-insurer furnish an initial written refusal to authorize the requested treatment or testing within the five business day period, then within 21 days of the initial receipt of the WC-205, the insurer/self-insurer shall either: (a) authorize the requested treatment or testing in writing; or (b) file with the Board a Form WC-3 controverting the treatment or testing indicating the specific grounds for the controversion.

(c) If medical treatment is controverted on the ground that the treatment is not reasonably necessary, the burden of proof shall be on the employer. If the treatment is controverted on the grounds that the treatment is either not authorized or is unrelated to the compensable injury, the burden of proof shall be upon the employee.

(d) If an employer or insurer utilizes a Board certified WC/MCO pursuant to O.C.G.A. § 34-9-201(b)(3), and a dispute arises regarding the treatment/test prescribed by the authorized treating physician and the dispute is not resolved within 30 days as outlined in Rule 208(f), then the employer or insurer has 15 days from notification by the WC/MCO to authorize the treatment/test or controvert the treatment/test. In no event will the employer or insurer utilizing a WC/MCO have more than 45 days from the receipt of the notice of a dispute as set forth in Rule 208(f) to comply with this provision.

(4) Where the employer fails to comply with Rule 205(b)(3), the employer shall pay, in accordance with the Chapter, for the treatment/test requested.

Rule 206. Reimbursement of Group Carrier or Other Healthcare Provider.

(a) Form WC-206, including supporting documentation, shall be submitted to the Board by the party seeking reimbursement during the pendency of the claim. Copies shall also be sent by the party requesting reimbursement to all counsel and unrepresented parties at interest.

(b) If a hearing request is pending when the Board receives a request for reimbursement and designation as a party at interest, the Board will provide the requesting party with notice of the hearing.

Rule 208. Managed Care Organization Rules.

(a) Application and certification.

(1) All provisions of this Rule constitute the minimum requirements necessary to obtain and maintain certification as a WC/MCO under the Georgia Workers' Compensation Act. To obtain certification of a plan, application shall be submitted on a Form WC-208a accompanied by a non-refundable fee of $1,000.00 and shall include the following information:

(A) An audited financial statement evidencing the ability of the Managed Care Organization to comply with any and all financial requirements to insure the delivery of services the Board may prescribe.

(B) Complete disclosure should be made of the following individuals (an individual may act in more than one capacity):

(1) The names, addresses and resume of all directors and officers of the WC/MCO;

(2) The title, name, address, telephone number and resume of the person to be the day-to-day administrator of the WC/MCO;

(3) The title, name, address, telephone number and resume of the person to be the administrator of the financial affairs of the WC/MCO;

(4) The name, address, medical specialty and resume of the medical director;

(5) The name, address and telephone number of the WC/MCO's communication liaison for the Board, the insurer, the employer, and the employee; and

(6) The name and address or any other information requested by the Board regarding any entity, other than individual health care providers, with whom the WC/MCO has a joint venture or other agreement to perform any of the functions of the managed care plan, and a description of the specific function to be performed by each entity.

(C) The WC/MCO must insure provisions of quality services that meet all uniform treatment standards required by Georgia law and provide appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service.

(D) The WC/MCO must provide a description of its proposed geographic service area by county and specify the times, places and manner of providing services, including a statement describing how the WC/MCO will insure that an adequate number of each category of health care provider is available to give employees convenient geographic accessibility to all categories of providers and adequate flexibility to choose health care providers from among those who provide services under the plan.

(E) The WC/MCO must include minority providers, and at a minimum, the following types of health care services and providers, unless the WC/MCO provides evidence that a particular service or type of provider is not available in the geographical service area:

(1) Medical doctors, including specialists in at least one of the following fields: family practice, internal medicine, occupational medicine, or emergency medicine;

(2) Orthopedic surgeons, including specialists in hand and upper extremity surgery;
(3) Neurologists and neurosurgeons;
(4) General surgeons;
(5) Chiropractors;
(6) Physical and occupational therapists;
(7) Psychologists or psychiatrists;
(8) Diagnostic pathology and laboratory services;
(9) Radiology services; and
(10) Hospital, outpatient surgery, and emergency care services.

(F) The WC/MCO must submit sample copies of all types of agreements with providers who will deliver services under the WC/MCO and a description of any other relationships with providers who may deliver services to a covered employee.

(G) The WC/MCO must attach to each type of sample agreement a corresponding list of names, clinics, addresses and types of license and specialties for the health care providers with whom they have utilized the agreement.

(H) In all agreements with the WC/MCO and any other provider of services, the agreement shall contain the following provision: “It is the intent of the parties to this agreement to insure quality services that meet all uniform treatment standards required by Georgia law, and any provision herein which may be inconsistent with that intent shall be void.”

(I) The WC/MCO must submit a statement certifying that all licensing requirements for the providers and medical case managers are current and in good standing in Georgia or the state in which the provider is practicing.

(J) The WC/MCO must provide a referral for specialty services that are not specified in subparagraph (E) and that may be reasonable and necessary to effect a cure or give relief as required under O.C.G.A. § 34-9-200. The employer or the workers' compensation insurance carrier remains liable for any health service required under the Workers' Compensation Act, provided that the services meet all other requirements of the Workers' Compensation Act.

(K) The WC/MCO must include procedures to insure that employees will receive services in accordance with the following criteria:

(i) The medical case manager shall inform the employee of his right to choose from the providers designated in Rule 208(a)(1)(E), inform the employee that a list of medical providers is available and provide assistance in obtaining the list if necessary. The medical case manager shall assist the employee in choosing a provider appropriate to the injury. The physician so chosen shall be deemed the “authorized treating physician” for all purposes under the Workers' Compensation Act. Employees must be allowed to change authorized treating physicians within the managed care plan at least once without proceeding through the managed care plan's dispute resolution process. In such cases, employees shall give notice to the manage care plan for a change in their authorized treating physician;

(ii) Employees must be able to receive information on a 24-hour basis regarding the availability of necessary medical services available within the managed care plan. The information may be provided through recorded toll-free telephone messages after normal working hours. The message must include information on how the employee can obtain emergency

services or other urgently needed care and how the employee can access an evaluation within a reasonable time after request;

(iii) Employees must receive initial evaluation by a participating licensed health care provider within twenty-four hours after the employee's request for treatment, following a work-related injury;

(iv) In cases where the employee has received treatment for the work injury by a health care provider outside the managed care plan, the employee must receive initial evaluation or treatment by a participating health care provider within five (5) working days of the employee's request for a change of doctor or referral to the managed care plan;

(v) Employees must receive any necessary treatment, diagnostic tests or specialty services in a manner that is timely, effective and convenient for the employee, and reasonable under the circumstances;

(vi) Employees must have reasonable access to health care providers. If the employee is medically unable to travel to a participating provider, the managed care plan shall refer the employee to an available or non-participating provider to receive necessary treatment for the injury.

(L) The WC/MCO must designate the procedures for approval of services from a health care provider outside the managed care plan.

(M) The WC/MCO must include a procedure for peer review and utilization, consistent with Rule 208(g).

(N) The WC/MCO must include a procedure for internal dispute resolution, including a method to resolve complaints by injured employees, medical providers, employers and insurers.

(O) The WC/MCO must inform employees of all choices of medical services provided within the plan and how employees can gain access to those providers including but not limited to a wallet-sized card containing this information in a format suitable for carrying on the employee's person. The plan must submit a proposed publication which may be customized according to the needs of the employer, but must include the information required in Rule 201(a)(3) and must also include a complete list of all WC/MCO medical providers in the applicable geographical service area. All employees of covered employers shall be provided with the publication.

(P) The WC/MCO must provide the information required by Rule 208(h) and describe how medical case management will be provided for injured employees, and an effective program for return-to-work and cooperative efforts by the employees, the employer and the managed care plan to promote workplace health and safety and other services.

(Q) The WC/MCO must provide such other information as the Board considers necessary to determine compliance with the Workers' Compensation Act.

(2) Within 60 days of receipt of an application, the Board must notify an applicant for certification of any additional information required or modification that must be made. The Board must notify the applicant in writing of the approval or denial of certification within 60 days of receipt of the additional information or modification. If certification is denied, the applicant must be provided, in writing, with the reason or reasons for the denial.

(3) Any person aggrieved by a denial of certification by the Board may make written request for a hearing within 30 days of the date the denial is served and filed. The Appellate Division shall hold all hearings and issue a final decision.

(b) Coverage responsibility of WC/MCO.

(1) A WC/MCO must contract with the employer or the workers' compensation insurer of an employer. In the event multiple WC/MCO's are contracted to cover the same employer, each employee shall have the initial election of the WC/MCO that will manage the employee's care, and utilization of a WC/MCO will be deemed an election.

(2) An employee who gives notice to an employer of a compensable injury shall receive medical services in the manner prescribed by the terms and conditions of the WC/MCO contract in effect at the time medical services are rendered.

(3) To insure continuity of care, the WC/MCO contract shall specify the manner in which an injured employee will receive medical services when a WC/MCO contract or contract with the health care provider terminates. The employee may continue to treat with the health care provider or the WC/MCO under the terminating contract until such time as the employee elects to utilize the employer's current posted panel of physicians, conformed panel of physicians or WC/MCO, or a change of physician is granted.

(c) Reporting requirements for Board certified WC/MCO's.

(1) A WC/MCO shall provide the Board with a copy of the following contracts:

(A) Contracts between the WC/MCO and any employer or workers' compensation insurer, prior to utilization of the contract. If the Board does not issue a written approval or denial within 90 days, then the contract shall be approved. Any contract rejected by the Board shall be deemed void for purposes of this Rule. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts must include a list of signatories and a listing of all employers covered by each contract, including the employers' name, business address and estimated number of employees governed by the WC/MCO. Amendments and addendums to the contracts must be submitted to the Board within 30 days of execution. Contract provisions must be consistent with O.C.G.A. § 34-9-208 and this Rule. The contract must specify the billing and payment procedures and how the medical case management and return-to-work functions will be coordinated.

(B) New types of agreements between participating health care providers and the WC/MCO that are not identical to the agreements previously submitted to the Board shall not be effective until approved by the Board. Any contract which is neither approved nor rejected by the Board within 90 days from submission shall be deemed approved.

(C) Contracts between the WC/MCO and any entity, other than individual participating providers that performs some of the functions of the WC/MCO.

(D) Any changes in the individuals or information required by Board Rule 208(a)(1)(B)(1)-(5).

(2) In order to maintain certification, each WC/MCO shall provide on the first working day following each anniversary of certification the following information in the form of a certified annual report:

(A) A current listing of all individuals identified in Board Rule 208(a)(1)(B)(1)-(5) and all participating health care providers, including provider names, types of license, specialty, business address, telephone number and a statement that all licenses are current and in good standing;

(B) A summary of any sanctions or punitive actions taken by the WC/MCO against any participating providers;

(C) A report that summarizes peer review, utilization review, supplier profiles, reported complaints and dispute resolution proceedings showing cases reviewed, issues involved, and any action taken; and
(D) An audited financial statement for the most recent fiscal year, upon request of the Board.
(E) The annual report must be accompanied by a non-refundable fee of $500.00.

(3) Any proposed changes to the Board certified WC/MCO falling within the categories enumerated below, other than changes to the health care provider list, may not be implemented under the plan until approved by the Board:
(A) Amendments to any contract with participating health care providers;
(B) Amendments to contracts between the WC/MCO and another entity performing functions of the managed care plan; and
(C) Any other amendments to the WC/MCO as certified.

(4) The WC/MCO must report to the employer or insurer any data regarding medical services and suppliers related to the workers' compensation claim required by the self-insured employer or insurer to determine compensability under the Workers' Compensation Act, and any other data required by the Board. The Board may require additional information from the managed care organization if the information is relevant to the Workers' Compensation Act.

(d) Commencement and termination of contract between the WC/MCO and participating providers.

(1) Prospective new participating health care providers under a WC/MCO shall submit an application to the WC/MCO. A director, executive director or administrator may approve the application under the requirements of the WC/MCO. The managed care plan shall verify that each new participating health care provider meets all licensing, registration and certification requirements necessary to practice in Georgia or other applicable state of practice.

(2) A participating provider may elect to terminate participation in the WC/MCO or to be subject to cancellation by the managed care plan under the requirements of the managed care plan. Upon termination of a provider contract, the managed care plan shall make alternate arrangements to provide continuing medical services for an affected injured employee under the plan in compliance with Board Rule 208(b)(3).

(e) A health care provider who is not a participating health care provider may provide medical services to an employee covered by a WC/MCO in any other circumstances provided below:

(1) Emergency treatment;
(2) When the employee is referred to the provider by the managed care organization;
(3) By order of the Board, or by consent of the parties.

(f) Disputes which arise on an issue related to managed care shall first be processed without charge through the dispute resolution process of the WC/MCO. The WC/MCO dispute resolution process must be completed within 30 days of a written notice. If the dispute cannot be resolved, the WC/MCO must immediately notify the employer or insurer. If the dispute involves treatment/test prescribed by the authorized treating physician, the employer or insurer must follow the procedure outlined in Rule 205.

(g) Utilization review and peer review.

(1) The WC/MCO must implement a system for peer review to improve patient care and cost effectiveness of treatment. Peer review must include a majority of health care providers of the same discipline being reviewed. The peer review

must be designed to evaluate the quality of care given by a health care provider to a patient or patients. The plan must describe in its application for certification how the providers will be selected for review, the nature of the review and how the results will be used.

(2) The WC/MCO must implement a plan for utilization review. The program must profile each medical supplier and include the collection, review, analysis of group data (utilizing CPT-4 codes) to improve overall quality of care, efficient use of resources and duration of disability. In its application for certification, the WC/MCO must specify the data that will be collected, how the data will be analyzed and how the results will be applied to improve patient care and increase cost effectiveness of treatment.

(h) Medical case management.

(1) The medical case manager must monitor, evaluate and coordinate the delivery of quality, cost effective medical treatment and other health services needed by an injured employee, and must promote an appropriate, prompt return to work. Medical case managers must facilitate communication between the employee, employee's representative, employer, employer's representative, insurer, health care provider, WC/MCO and, when authorized, any qualified rehabilitation consultant to achieve these goals. The WC/MCO must describe in its application for certification how injured employees will be subject to case management, the services to be provided, and who will provide services.

(2) Case management for an employee covered by a WC/MCO must be provided by a licensed registered health care professional holding one of the following certifications: Certified Rehabilitation Registered Nurse (CRRN), Certified Case Manager (CCM), Certified Occupational Health Nurse (COHN), Certified Occupation Health Nurse Specialist (COHN-S), Certified Disability Management Specialist (CDMS), Certified Rehabilitation Counselor (CRC), Work Adjustment/Vocational Evaluation Specialist (WAVES), or Licensed Professional Counselor (LPC). Case managers must have at least one year experience in workers' compensation. In catastrophic cases, case management must include assignment to a Board-registered rehabilitation supplier, who has been designated by the board as qualified to manage catastrophic cases (Rule 200.1 (f)(4)). If qualified, the case manager may register with the Board to serve as the catastrophic rehabilitation supplier.

(3) The parties to the claim and their representatives shall cooperate with medical case management services when such services are being provided by a WC/MCO which has been certified pursuant to O.C.G.A. § 34-9-208 and Board Rule 208 and which has posted a WC-P3 panel. The unreasonable refusal to cooperate with or the unreasonable interference with medical case management services by any party or its representative may subject that party or its representative to civil penalties pursuant to O.C.G.A. § 34-9-18. The employer/insurer may suspend weekly benefits for the failure of the employee to cooperate with medical case management only by order of the Board.

(i) Monitoring records.

(1) The Board shall monitor and may conduct audits and special examinations of the WC/MCO as necessary to insure compliance with the WC/MCO certification and performance requirements.

(2) All records of the WC/MCO and its participating health care providers relevant to determining compliance with the Workers' Compensation Act shall be disclosed in a reasonable time after request by the Board. Records must be legible and cannot be kept in a coded or semi-coded manner unless a ledger is provided for codes.

(3) The release of records filed with the Board must clearly identify the portions of the application or records which are believed to be non-public trade secret data or otherwise confidential.

(j) Suspension; revocation.

(1) The WC/MCO shall work with all parties and their representatives in a reasonable manner consistent with the purposes of this Act. Complaints pertaining to violations by the WC/MCO shall be directed in writing to the Board. Upon receipt of a written complaint or after monitoring the managed care plan operation, the Board shall investigate the alleged violation. The investigation may include, but shall not be limited to, requests for and review of pertinent managed care records. If the investigation reveals reasonable cause to believe that there has been a violation warranting suspension or revocation of certification, the Board shall schedule a hearing.

(2) The certification of any WC/MCO issued by the Board may be suspended or revoked, in the discretion of the Board, if the WC/MCO fails to meet any of the requirements of O.C.G.A. § 34-9-208 or Board Rule 208.

(3) For purposes of this Rule, “suspension” and its variations means the cessation of the WC/MCO's authority to enter into new contracts with employers or insurers for a specified period of time up to a maximum of one (1) year. Upon suspension, the WC/MCO may continue to provide services in accordance with the contracts in effect at the time of the suspension. A suspension may be set aside prior to the end of the designated suspension period if it is shown to the satisfaction of the Board that the WC/MCO is in compliance. Furthermore, if it is shown that the WC/MCO is not in compliance immediately prior to the end of the designated suspension period, the suspension may be extended without further hearing, or revocation proceedings may be initiated.

(4) For purposes of this Rule, “revocation” and its variations means a revocation of a WC/MCO's certification to provide services under these Rules. If the WC/MCO certification is revoked, no employee is covered by the contract between the WC/MCO and the employer or workers' compensation carrier. However, upon revocation of certification, the WC/MCO may continue to provide services under contracts in effect to the extent the Board determines that it is necessary for injured employees to continue to receive medical services in that manner.

(5) Suspension or revocation under this Rule will not be made until the WC/MCO has been given notice and the opportunity to be heard through a show-cause hearing before the Board. The Board shall provide the WC/MCO written notice of an intent to suspend or revoke the WC/MCO's certification and the grounds for such action. The notice shall also advise the WC/MCO of the right to participate in the show-cause hearing and specify the date, time and place of the hearing. The notice shall be issued from the Board at least twenty-one (21) days prior to the scheduled date of the hearing. After the show-cause hearing, the Board may issue a final order suspending or revoking the WC/MCO's certification.

(6) Upon revocation of a WC/MCO's certification, the employer or the workers' compensation insurer of an employer with whom the revoked WC/MCO had been contracted to provide managed care shall make alternate arrangements to provide continuing medical services for injured employees who had been receiving medical care through the revoked WC/MCO. Any injured employee receiving medical services through a WC/MCO prior to revocation of the WC/MCO's certification may continue to treat with one of the individual health care providers with whom the employee had received medical services prior to revocation until such time as the employee elects to utilize the employer's replacement posted panel of physicians, conformed panel of physicians or WC/MCO, or a change of physician is ordered.

Rule 220. Computing Days of Disability Preceding Payment of Compensation.

(a) The date of disability is the first day the employee is unable to work a full day. If, however, the employee is paid in full for the date of injury, the date of disability shall begin the next day following the date of injury.
   (1) The day or days considered lost because of disability to work shall be counted from the first seven calendar days of disability even though the days may not be consecutive.
   (2) Intervening days, which are not scheduled workdays, during disability or preceding a return to work, are days of disability.
   (3) Disability shall end on the day of the return to work.

(b) Entitlement to benefits for the first seven days of disability, or any part thereof, requires 21 consecutive days of disability. The employer/insurer shall pay compensation for the first seven days of disability on the 21st consecutive day.

(c) An injured employee who receives regular wages during disability shall not be entitled to weekly benefits for the same period.

Rule 221. Method of Payment.

(a) Mail or deliver payment to the address specified by the employee or the address of record. The payment shall be considered paid when postmarked and mailed within the State of Georgia or three days from the date of postmark and mailing if mailed out of the State. Payment shall be made in cash, by negotiable instrument, or, upon agreement of the parties, by electronic funds transfer. The payment shall also denote the pay period for which the payment represents.

(b) For the purpose of calculating time periods, the date of injury shall be deemed to be the date of disability and a week shall be deemed to be seven calendar days. See Rule 220(a).

(c) In all cases, including payment of salary for compensable disability, upon making the first payment and upon suspension of payment, use Forms WC-1 or WC-2 or, in case of death, Form WC-2A. The Forms WC-1 or WC-2 must show payment of maximum weekly benefits under O.C.G.A. § 34-9-261 or § 34-9-262, as applicable, unless Form WC-6 or other explanation accompanies the Forms WC-1 or WC-2, or is already on file. To report any change in weekly benefits, payment of salary during period of compensability, classification, or rating of disability, use Form WC-2. An injured employee who receives regular wages during disability shall not be entitled to weekly benefits for the same period.

(d) To controvert in whole or in part the right to income benefits or other compensation, use Forms WC-1 or WC-3. Failure to file the Forms WC-1 or WC-3 before the 21st day after knowledge of the injury or death may subject the employer/insurer to an assessment of penalties or attorney's fees. See paragraphs (2) and (3) of subsection (b) of O.C.G.A. § 34-9-108.

(e) Any penalty for late payment shall be stated as a separate item on Forms WC-1, WC-2 or WC-2A.

(f) Accrued benefits payable under the terms of an award are due on the date the award is issued.

(g) Within 30 days after final payment of compensation, a final Form WC-4 shall be filed with the Board.

(h) Subsection (h) of O.C.G.A. § 34-9-221 applies only when income benefits are being paid under Forms WC-2, WC-2A, or subsection B of Form WC-1. To suspend payment on the ground of a change in condition, file Forms WC-2 or WC-2A.
(1) A Form WC-3 shall not be used to suspend benefits where the only issue is length of disability. In these cases, suspend benefits by filing a Form WC-2 or follow procedure outlined in Rule 240. If liability is denied subsequent to commencement of payment, but within 60 days of due date of first payment of compensation, file Form WC-3 in addition to a Form WC-2.
(2) If income benefits have been continued for more than 60 days after the due date of first payment of compensation, benefits may be suspended only on the grounds of a change in condition or newly discovered evidence. File Forms WC-2 or WC-2A. When controverting a claim based on newly discovered evidence, file Form WC-3 also.

(i) (1) Suspension of benefits at any time on the ground of change in condition requires advance notice of 10 days unless the employee has actually returned to work.
(2) The date of filing with the Board, in the absence of compelling evidence to the contrary, shall be considered the date of filing.
(3) The date affixed by the Board to Forms WC-2 or WC-2A, in the absence of compelling evidence to the contrary, shall be considered the date of filing.
(4) When suspending benefits for release to return to work without restriction, the employer/insurer shall attach to the Form WC-2 a copy of the supporting medical report from employee's authorized treating physician, provided that the physician has examined the employee within sixty days of the effective date of the release.

Rule 222. Time Limit for Application for Lump Sum Payment.

(a) The Board will consider an application for a lump sum payment of all remaining income benefits or a lump sum advance of a portion of the remaining income benefits, but will not consider any application unless benefits have been continued for at least 26 weeks. The employer/insurer may make a lump sum payment or lump sum advance without commutation of interest and without an award from the Board.

(b) In lieu of a hearing, the Board will consider applications for lump sum advances and lump sum payments in accordance with the following procedure:
(1) A request for a lump sum advance or lump sum payment must be submitted on Form WC-25, and a copy must be sent to the employer/insurer and any other interested parties. The request will not be granted unless the current Form WC-25 is completely filled out with appropriate supporting documents as directed on the form.
(2) The parties have 15 days from the date of the certificate of service to file objections to the application. Objections to an application must be accompanied by documents in support of the objections, may be accompanied by counter-affidavits, and must be served upon the party or the attorney making the application. A certificate of service must accompany the objections attached.
(3) If any party elects to cross-examine an adverse party, it must notify the Board within 15 days of the date of the certificate of service of the Form WC-25 of its intention to submit a deposition. The deposition must be filed with the Board no

later than 30 days from the certificate of service on the Form WC-25, unless an extension is granted by the Board upon a showing of just cause.

(4) If, in the judgment of the Board, there are material and bona fide disputes of fact, the Board may schedule a hearing or assign the case to an Administrative Law Judge for the purpose of receiving evidence, or schedule a mediation conference on the issues.

(5) The maximum amount of attorney fees which will be awarded in conjunction with an advance will be 25 percent of the amount of the advance or $500.00, whichever is less, unless specifically authorized by the Board. In the event the attorney obtaining the advance has a fee contract that has been previously approved by order or award of the Board, attorney fees will be authorized in accordance with the terms of the order or award.

Rule 226. Procedures for Appointing Guardian for Minor or Incompetent Adult.

(a) A petition for the Board to appoint a temporary guardian to bring or defend an action under this chapter and/or to receive and administer workers' compensation benefits for a minor or incompetent adult should be filed with the Board at the time the WC-14 is filed. In the case of a stipulated settlement, the guardianship petition should be filed prior to or at the time of the filing of the stipulated settlement agreement. If payment to the minor or incompetent adult is pursuant to a WC-2, the guardianship petition should be filed with the Board and a guardian appointed prior to the payment of any monetary benefits to them.

(b) Any applicant for guardianship must submit proof of a criminal history record check at the time the petition for guardianship is submitted to the Board. When the petitioner resides, or has resided, in a jurisdiction other than Georgia within the five years prior to the date of the petition for guardianship, the petitioner must submit a certified copy or other proof of a criminal history record check from all jurisdictions of residence.

Rule 240. Offer of Suitable Employment.

(a) For suspension and reinstatement of income benefits by interlocutory order generally, see Board Rule 102D.

(b) When an employee unjustifiably refuses to accept employment which has been approved by the authorized treating physician(s) suitable to his/her impaired condition and offered to the employee in writing, the employer/insurer may suspend payment of income benefits to that employee without an order of the Board in the following manner:

(1) File with the Board a Form WC-2 and Form WC-240 certifying that at least ten days before the employee was required to report for work he/she was notified on the completed Form WC-240 mailed to the employee and his/her attorney that there was a suitable job available, that it was approved by his/her authorized treating physician(s) after an examination within the last 60 days, and refusal to attempt to perform the job would result in the suspension of payment of weekly income benefits to the employee. The employer/insurer should provide to the employee and legal counsel a copy of any job description/analysis in reference to subparagraph (2)(i), (ii) and (iii) at the time of submission to the authorized treating physician(s).

(2) Attached to the Form WC-240 shall be:

(i) A description of the essential job duties to be performed, including the hours to be worked, the rate of payment, and a description of the essential tasks to be performed;

(ii) The written approval of the authorized treating physician(s) of the essential job duties to be performed;

(iii) The location of the job, with the date and time that the employee is to report to work.

Attaching a properly completed Form WC-240A will satisfy the requirements for making a proper offer of employment as set forth herein.

(3) If the employee refuses to attempt to perform the proffered job after receiving the above notification, the employer/insurer shall be authorized to suspend payment of income benefits to the employee effective the date that they unjustifiably refused to report to work.

(c) Should the employee accept the employment offered by the employer/insurer but fail to continue working for more than the prescribed fifteen (15) scheduled work days, the employer/insurer, whether or not they have sent a WC-240, shall immediately reinstate payment of income benefits and shall file with the Board and serve upon the employee the appropriate Form WC-2 reflecting the reinstatement of income benefits.

(i) Failure to immediately reinstate benefits pursuant to Board Rule 240 (c), shall result in the waiver of the employer/insurer's defense of the suitability of employment for the period of time the employer/insurer did not pay the employee's weekly income benefits when due.

(ii) When the employer/insurer immediately reinstates benefits pursuant to Board Rule 240 (c), the employer/insurer are entitled to seek reimbursement of such benefits at a hearing addressing the suitability of the proffered employment

(d) When calculating the fifteen (15) scheduled work days provided by statute, the employer/insurer shall include as a work day each day or part thereof during which the employee is scheduled to perform his/her job duties.

(e) The employer/insurer shall also be entitled to suspend payment of weekly benefits to the employee pending a hearing by an order of the Board finding an unjustifiable refusal of the employee to accept employment procured for him/her suitable to his/her capacity. A motion requesting this order may be made simultaneously with the filing of a request for hearing or at any time during the pendency of the hearing and award and shall be filed on Form WC-102D, and must be accompanied by an affidavit from the employer setting forth that suitable employment has been offered to the employee as set forth in (b) above, the offer is continuing, and analysis of the job is attached. The employer/insurer shall have the employee examined by the authorized treating physician(s) within 60 days prior to this request for suspension of income benefits. No request for suspension of income benefits for failure to accept suitable employment shall be granted unless the authorized treating physician(s) approve(s) the job offered by the employer/insurer. A party who objects to this motion shall file their response on Form WC-102D with the Board within 15 days of the date of the certificate of service on the request, and shall serve a copy on all counsel and unrepresented parties.

(f) The Board may also issue an interlocutory order reinstating weekly income benefits pending a hearing. A party making this motion shall file Form WC-102D, and shall serve a copy, along with a copy of supporting documents, on all counsel and unrepresented parties. A motion requesting this order may be made simultaneously with the filing of a request for hearing based on a change in condition or at any time during the pendency of the hearing and award and must be accompanied by an affidavit of the employee setting forth his contentions, along with current medical records when applicable. A party who objects to this motion shall file Form WC-102D with the Board within 15 days of the date of the Certificate of Service on Form WC-102D and shall serve a copy on all counsel and unrepresented parties.

(g) In the event the employee's weekly benefits are suspended pursuant to O.C.G.A. 34-9-240(b)(2), the employer/insurer shall comply with O.C.G.A. 34-9-263 and Board Rule 263.

Rule 243. Credit for Payment of Income Benefits.

An employer/insurer seeking a credit as provided by O.C.G.A. § 34-9-243 shall file with the Board Form WC-243, and shall report on Form WC-243 the amount of unemployment compensation and/or weekly income payments made on behalf of an employee pursuant to a disability plan, a wage continuation plan, or a disability insurance policy and shall set forth the ratio of the employer's contributions to the total contributions of such plan or policy no later than 10 days prior to a hearing. A copy of this form shall be sent to all counsel and unrepresented parties by the employer/insurer at the same time that it is filed with the Board.

Rule 244. Reimbursement for Payment of Disability Benefits.

A provider of disability benefits who requests reimbursement shall file Form WC-244 with the Board, and shall serve a copy on all counsel and unrepresented parties.

Rule 260. Basis for Computing Compensation.

(a) Computation of wages shall include, in addition to salary, hourly pay, or tips, the reasonable value of food, housing, and other benefits furnished by the employer without charge to the employee which constitute a financial benefit to the employee and are capable of pecuniary calculation.

(b) Unless the contrary appears, it is assumed that a normal workweek is five days, that the normal workday is eight hours, and that the employee's daily wage is one-fifth of the weekly pay. Fractional parts of a day shall be credited proportionately in computing the daily wage. For example, the daily wage of a five-and-one-half day worker is the weekly wage divided by 5.5.

(c) If the employee has similar concurrent employment the wages paid by all similar concurrent employers shall be included in calculating the average weekly wage.

Rule 261. Reserved.

Rule 262. Computing Temporary Partial Disability.

(a) The average weekly wage the employee is able to earn after the injury may be determined according to the method of computation in O.C.G.A § 34-9-260(1).
   (1) An employer/insurer using this method may recompute the average weekly wage after payment of benefits begin under O.C.G.A. § 34-9-262 and at 13-week intervals thereafter.
   (2) In lieu of calculating an average weekly wage after injury based on 13-week intervals, the employer/insurer may elect to calculate benefits due each week by multiplying two-thirds times the difference between the average weekly wage on the date of injury and the actual weekly wage the employee earned each week thereafter.

(b) For the purposes of calculating temporary partial benefits as contemplated by O.C.G.A. § 34-9-104(a)(2), see method of calculation set forth in O.C.G.A. § 34-9-104(a)(3).

Rule 263. Determination of Disability Rating.

When the employee is no longer receiving weekly benefits under O.C.G.A. 34-9-261 or 34-9-262, and a permanent partial disability (PPD) rating has not previously been requested or issued, the employer/insurer shall have thirty days to request, in writing, from an authorized physician, that the employee be rated in accordance with the "Guides to the Evaluation of Permanent Impairment, Fifth Edition," published by the American Medical Association. The employer/insurer shall furnish a copy of the medical report of rating to the employee, and commence payment not later than 21 days after knowledge of the rating. The employer/insurer are presumed to have knowledge of the rating not later than 10 days after the date of the report establishing the rating.

Rule 265. Payment of No-Dependency Benefits Into the General Fund of the State Treasury.

The insurer or self-insurer in no-dependency death cases, shall pay to the State Board of Workers' Compensation the amount set forth in Code Section 34-9-265(b).

Rule 380. Establishment of the Self-Insurers Guaranty Trust Fund.

Rule 381. Definitions as used in this Article.

(a) "Applicant" means an employee entitled to workers' compensation benefits.

(b) "Board" means the State Board of Workers' Compensation.

(c) "Board of trustees" means the Board of trustees of the Fund.

(d) "Fund" means the Self-Insurers Guaranty Trust Fund.

(e) "Insolvent self-insurer" means a self-insurer who files for relief under the Federal Bankruptcy Act, a self-insurer against whom involuntary bankruptcy proceedings are filed, or a self-insurer for whom a receiver is appointed in a federal or state court of this or any other jurisdiction and who is determined to be insolvent by rules and regulations promulgated by the Board of trustees and approved by the Board.

(f) "Participant" means a self-insurer who is a member of the Fund.

(g) "Self-insurer" means a private employer, including any hospital authority created pursuant to the provisions of Article 4 of Chapter 7 of Title 31, the "Hospital Authorities Law," that has been authorized to self-insure its payment of workers' compensation benefits pursuant to this Chapter, except any governmental self-insurer or other employer who elects to group self-insure pursuant to Code Section 34-9-152, or captive insurers as provided for in Chapter 41 of Title 33, or employers who, pursuant to any reciprocal agreements or contracts of indemnity executed prior to March 8, 1960, created funds for the purpose of satisfying the obligations of self-insured employers under this chapter.

(h) "Trustee" means a member of the Self-Insurers Guaranty Trust Fund Board of Trustees.

Rule 382. Purpose.

(a) The purpose of creating a Self-Insurers Guaranty Trust Fund is to make payments in accordance with this chapter for the benefit of workers injured on the job in the event a participant becomes insolvent. The Fund shall be administered by an administrator appointed by the Chairman of the Board of trustees with approval of the Board of

trustees. Monies in the Fund will be invested by the Board of trustees in the same manner as provided by law for investments in government backed securities.

(b) All returns on investment shall be retained by the Fund. In addition to paying benefits, and administrative fees, operating costs of the Board of trustees, attorneys' fees incurred by the Board of trustees and other costs reasonably incurred by the Board will be paid from this Fund.

(c) As a condition of self-insurance a private employer must make application and be accepted in the Self-Insurers Guaranty Trust Fund.

(d) Self-insurers must give written notice to the Board addressed to the Director of Licensure and Quality Assurance when they add or delete subsidiaries, affiliates, divisions or locations to their self-insurance certificate, or make any changes in their excess insurance policies. (See Rule 126(c).)

Rule 383. Board of Trustees; How Appointed.

(a) Each member of the Board of trustees shall be an employee of a participant. The Board of trustees shall consist of a chairperson and six trustees elected by the participants. The Board of trustees shall initially be appointed by the Governor not later than August 1, 1990. Three of the initial trustees shall be appointed for terms of office which shall end on January 1, 1993, and the chairperson and the three other initial trustees shall be appointed for terms of office which shall end on January 1, 1995. Thereafter, each trustee shall be elected to a four-year term and shall continue to serve unless otherwise ineligible under subsection (b) of this Code section. No later than 90 days prior to the end of any member's term of office, the chairperson shall select a nominating committee from among the participants to select candidates for election by the participants for the following term. In the event the chairperson fails to complete his or her term of office, a successor will be elected by the Board of trustees to fill the unexpired term of office.

(b) A vacancy in the office of the Board of trustees shall occur for the following reasons:
(1) Resignation;
(2) Death;
(3) Conviction of felony;
(4) Employer no longer qualifies as a self-insured participant;
(5) Trustee is no longer an employee of the participant.

(c) The Board of trustees may remove any member from office for:
(1) Formal finding of incompetence;
(2) Neglect of duty; or
(3) Malfeasance in office.

(d) The Board of trustees, within 30 days after the office of any elected member becomes vacant, shall elect a successor for the unexpired term.

Rule 384. Powers of the Board of Trustees.

The Board of trustees shall possess all powers necessary to accomplish objectives prescribed in this article including the following:

(a) Submit to the Board, for approval within 90 days from appointment, bylaws, rules, regulations, resolutions and application fee of $500.00. Board of trustees may carry out its responsibilities by contract or other instrument; may purchase services, borrow

money, purchase excess insurance, levy penalties and fines, and collect funds necessary to effectuate its activities. The Board of trustees shall appoint, retain and employ staff necessary to achieve the purposes of the Board of trustees with expenses incurred paid from the Fund.

(b) The Board of trustees shall meet quarterly or upon the call of the chairman issued to the trustees in writing not less than 48 hours prior to the day and hour of the meeting; upon a request submitted to the chairman 72 hours prior to the proposed day and hour by a majority of the trustees whereupon the chairman will provide notice as set forth above or by unanimous written agreement of the trustees.

(c) Four trustees constitute a quorum.

(d) The Board of trustees shall serve without compensation; each member will be entitled to reimbursement for actual expenses incurred in the discharge of his official duties.

(e) The Board of trustees shall have the right to bring and defend actions in the name of the Fund. Neither trustees nor their employers shall be liable for matters arising from or out of authorized conduct of the Fund in accordance with this article.

Rule 385. Participant Filing for Relief Under the Federal Bankruptcy Act.

(a) Within 30 days of the occurrence of filing for relief under the Federal Bankruptcy Act or against whom bankruptcy proceedings are filed or for whom a receiver is appointed, the participant shall file a written notice with the Board and the Board of trustees.

(b) Any person filing an application for adjustment of a claim against a participant who has filed for relief under the Federal Bankruptcy Act, or against whom bankruptcy proceedings have been filed or a receiver appointed must file a written notice with the Board and the Board of trustees within 30 days of such person's knowledge.

(c) Upon receipt of any notice as provided in subsections (a) and (b) of this Code Section, the Board of trustees shall refer for investigation all facts, circumstances, and information in its possession to a properly designated authorized certified public accountant for determination of the question of insolvency according to generally accepted accounting principles. Upon receipt of the notice referenced herein, a participant shall be required to execute a release of any and all financial information, banking records, books of account, tax returns or other records determined by the Board of trustees to be necessary in making a determination of insolvency and the participant shall assist in the production of said information when requested to do so by the Board of trustees.

(d) When a participant is determined to be an insolvent self-insurer, the Board of trustees is empowered and shall assume on behalf of the participant the following:
  (1) Outstanding workers' compensation obligations excluding penalties, fines and claimant's attorney fees assessed pursuant to § 34-9-108(b).
  (2) Responsibility for taking necessary steps to collect, recover, and enforce all outstanding securities, indemnity, insurance, or bonds for the purpose of paying outstanding obligations of participants.
  (3) Refunding any funds remaining from such securities to the appropriate party one year from the date of final payment, provided no liabilities remain against the Fund.

(e) The Board of trustees shall be a party in interest in all proceedings in the payment of workers' compensation claims for a participant and shall be subrogated to the rights of

the participant. The Board of trustees may exercise all rights and defenses of the participant including:

(1) Appear, defend and appeal claims.
(2) Receive notice of, investigate, adjust, compromise, settle and pay claims.
(3) Investigate, handle and controvert claims.

(f) Should payment of benefits be stayed in bankruptcy court, the Board of trustees or a designated representative shall appear in the bankruptcy court and move to lift the stay.

(g) The Board of trustees shall notify all employees with pending claims of the name, address and telephone number of the party administering and defending against their claim.

(h) The Board has the discretion to direct the Fund to pay, in whole or in part, the contractual fee arrangement between an attorney and a claimant pursuant to § 34-9-108(a). The attorney must apply to the Board and provide notice to the employee with a pending claim. Any party may make an objection to the application and all objections will be considered by the Board.

(i) This code section shall not impair any claims, to the extent those claims are unpaid, in the insolvent self-insurer's bankruptcy which have been filed by a provider of services. Provider of services includes, but is not limited to, medical providers or the attorneys representing the insolvent self-insurer or the claimant, if the services provided are related to the insolvent self-insurer's workers' compensation obligations.

Rule 386. Method of Assessment.

(a) (1) The Board of trustees shall, commencing January 1, 1991, assess each participant in accordance with paragraph (2) of this subsection. Upon reaching a funded level of $10 million, all annual assessments against participants who have paid at least three prior assessments shall cease except as specifically provided in paragraph (4) of this subsection.

(2) Assessment for each new participant in the first calendar year of participation shall be $4,000.00. Thereafter, assessments shall be in accordance with paragraphs (3) and (4) of this subsection.

(3) After the first calendar year of participation, the assessment of each participant shall be made on the basis of a percentage of the total of indemnity benefits paid by, or on behalf of, each participant during the previous calendar year. Except as provided in paragraph (2) of this subsection for the first calendar year of participation and paragraph (4) of this subsection, a participant will not be assessed at any one time an amount in excess of 1.5 percent of the indemnity benefits paid by that participant during the previous calendar year or $1,000.00, whichever is greater. The total amount of assessments, not including those set out in paragraph (4) of this subsection, in any calendar year against any one participant shall not exceed the amount of $4,000.00.

(4) If after the full funded level of $10 million has been attained, the fund is reduced to an amount below $7 million as the result of the payment of claims, the administration of claims, or the costs of administration of the Fund, the Board of trustees shall levy a special assessment of the participants in an amount sufficient to increase the funded level of $10 million.

(5) Funds obtained by such assessment shall be used only for the purposes set forth in this article and shall be deposited upon receipt by the Board of trustees into the fund. If payment of any assessment made under this article is not made within 30 days of the sending of the notice to the participant, the Board of trustees is authorized to proceed in court for judgment against the participant,

including the amount of the assessment, the costs of suit, interest, and reasonable attorneys' fees or proceed directly against the security pledged by the participant.

(b) (1) The Fund shall be liable for claims arising out of injuries occurring after January 1, 1991; provided, however, no claim may be asserted against the Fund until the funding level has reached $1.5 million.

(2) All participants shall be required to maintain surety bonds or the Board of trustees may, in its discretion, accept any irrevocable letter of credit or other acceptable forms of security in the amount of no less than $100,000.00 until the Board, after consultation with the Board of trustees, has determined that the financial capability of the trust fund and the participant no longer warrants any form of security.

(c) A participant who ceases to be a self-insurer shall be liable for any and all assessments made pursuant to this code section as long as indemnity compensation is paid for claims which originated when the participant was a self-insurer. Assessments of such a participant shall be based on the indemnity benefits paid by the participant during the previous calendar year.

(d)Upon refusal to pay assessments, penalties, or fines to the Fund when due, the Fund may treat the self-insurer as being in noncompliance with this Chapter and the self-insurer shall be subject to revocation of its Board authorization to self-insure.

Rule 387. Rights and Obligations of Board of Trustees to Obtain Reimbursement from Participant.

(a) The Board of trustees shall have the right and obligation to obtain reimbursement from any participant for compensation obligations in the amount of the participant's compensation obligations assumed by the Board of trustees and paid for claims as well as reasonable administrative and legal costs. The amount of the claims for reimbursement of reasonable administrative and legal costs shall be approved by the Board of trustees.

(b) The Board of trustees shall have the right to use the security deposit of a participant, its excess insurance carrier, and from any other guarantor to pay the participant's workers' compensation obligations assumed by the Board of trustees including attorneys' fees and legal costs.

Rule 388. Duties of the Board to Board of trustees.

(a) Report to Board of trustees when the Board has cause to believe participant examined may be in danger of insolvency.

(b) The Board shall, at the inception of the participant's self-insured status and at least annually thereafter, so long as the participant remains self-insured, furnish the Board of trustees with a complete, original bound copy of each participant's audit performed in accordance with generally accepted auditing standards by an independent certified public accounting firm, three to five years of loss history, name of the person or company to administer claims, and any other pertinent information submitted to the Board to authenticate the participant's self-insured status. The Board of trustees may contract for the services of a qualified certified public accountant or firm to review, analyze, and make recommendations on these documents. All financial information submitted by a participant shall be considered confidential and not public information.

(c) The Board of trustees shall make reports and recommendation to the Board on any matter germane to solvency, liquidation or rehabilitation of any participant. Reports and documents shall not be considered public documents.

(d) The Board of trustees shall review all applications and shall make recommendations to the Board for acceptance of self-insurers. If the Board rejects the recommendations of the Board of trustees, the Board shall notify the Board of trustees in writing within ten days prior to accepting the application for self-insurance.